

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1346	I	FROM 1/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
					I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT

DATE: 5/27/2009

TIME 16:06

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FAYETTE COUNTY HOSPITAL 14-1346
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/27/2009 TIME 16:06

5UgEzdhqM8QvWlEb1zrZ75wB.1lhn0
Dwiu50eRS6Fya9zbaGb:EZ5gxd.75i
I:Pe0jYmqi0R3wjw

PI ENCRYPTION INFORMATION
DATE: 5/27/2009 TIME 16:06

FeBSze8seTEN8j9zv6Q2.JDy:hNry0
pYcxe09FTazLozTZxHYKLAUIAXfVA.
K2:z4Ee9470cq6My

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V		TITLE XVIII		TITLE XIX	
		1		2		3	4
1	HOSPITAL	0		-174,599		187,873	0
3	SWING BED - SNF	0		21,345		0	0
5	HOSPITAL-BASED SNF	0		0		0	0
100	TOTAL	0		-153,254		187,873	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
CARE COMPLEX	I	14-1346	I	FROM 1/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
COST REPORT CERTIFICATION	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
AND SETTLEMENT SUMMARY	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT

DATE: 5/27/2009 TIME 16:07

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FAYETTE COUNTY HOSPITAL 14-1346

FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

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	1	A	B	4	
		2	3		
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Health Financial Systems MCRIF32 FOR FAYETTE COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96 (12/2008)
 HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
 I PROVIDER NO: 14-1346 I PERIOD: 1/ 1/2008 I PREPARED 5/27/2009
 I I FROM 1/ 1/2008 I WORKSHEET S-2
 I I TO 12/31/2008 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: SEVENTH & TAYLOR P.O. BOX:
 1.01 CITY: VANDALIA STATE: IL ZIP CODE: 62471- COUNTY: FAYETTE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00 HOSPITAL	FAYETTE COUNTY HOSPITAL	14-1346		4/ 1/2005	N	O	O
04.00 SWING BED - SNF	FAYETTE COUNTY SNF	14-2346		4/ 1/2005	N	O	N
06.00 HOSPITAL-BASED SNF	FAYETTE COUNTY SNF	14-5499		7/ 1/1983	N	P	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 N Y

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

3.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

3.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

3.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

3.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

3.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

3.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

3.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

4 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy) / /

4.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

5 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

5.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N

5.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

5.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

5.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

5.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

Health Financial Systems	MCRIF32	FOR FAYETTE COUNTY HOSPITAL	IN LIEU OF FORM CMS-2552-96 (12/2008) CONTD		
HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	I	PROVIDER NO: 14-1346	I	PERIOD: FROM 1/1/2008 TO 12/31/2008	I PREPARED 5/27/2009 WORKSHEET S-2

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)				
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /				
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /				
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y		6/25/2001	
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	N			
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)		1	2	3 4
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY		100	0.8335	0.8386
			0.00	2	14 99914

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

28.03	STAFFING	%	Y/N
28.04	RECRUITMENT	1.00%	Y
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	

9	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
0	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y
0.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N
0.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N
0.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
0.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
1	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
1.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
1.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
1.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
1.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
1.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N

ESCELLANEOUS COST REPORT INFORMATION

2	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N
3	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N N
4	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N
5	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
6.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
6.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
6.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
6.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	V	XVIII XIX
	1	2 3

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N

36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N

37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N

37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y

38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N

38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N

38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N

38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? Y

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y

40.01 NAME:	FI/CONTRACTOR NAME	FI/CONTRACTOR #
40.02 STREET:	P.O. BOX:	
40.03 CITY:	STATE: ZIP CODE: -	

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y

42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N

44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N

45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000

SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? N

45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? N

45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N

46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
17.00 HOSPITAL	N	N	N	N	N
19.00 SNF	N	N			

2 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N

2.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N

3 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

3.01 MDH PERIOD: BEGINNING: / / ENDING: / /

4 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:

PREMIUMS: 0

PAID LOSSES: 0

AND/OR SELF INSURANCE: 0

4.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

5 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
6 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. N 0.00 0					
6.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0					
6.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					
6.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					

7 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

8 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

3.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

9 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
 ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW
 FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN
 THIS FACILITY IN ITS MOST RECENT COST REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES OR
 "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH
 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y,
 ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3. (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING
 PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC
 YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS) 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA?
 ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3,
 CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS
 ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH"
 DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

COMPONENT		NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	----- I/P DAYS / TITLE V 3	O/P VISITS / TITLE XVIII 4	NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	21	7,686	8,568.00		2,446		378
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					1,383		
4	ADULTS & PED-SB NF							13
5	TOTAL ADULTS AND PEDS	21	7,686	8,568.00		3,829		391
6	INTENSIVE CARE UNIT	4	1,464	696.00		234		
12	TOTAL	25	9,150	9,264.00		4,063		391
13	RPCH VISITS							
15	SKILLED NURSING FACILITY	16	5,856			1,800		
16	NURSING FACILITY	69	25,254					
25	TOTAL	110						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		----- I/P DAYS / TITLE XIX OBSERVATION BEDS ADMITTED 5.01	NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			3,311				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			1,383				
4	ADULTS & PED-SB NF			13				
5	TOTAL ADULTS AND PEDS			4,707				
6	INTENSIVE CARE UNIT			331				
12	TOTAL			5,038				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			2,172				
16	NURSING FACILITY			22,855				
25	TOTAL							
26	OBSERVATION BED DAYS			459		459		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

COMPONENT		I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	----- DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					896	158	1,283
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
12	TOTAL		169.55			896	158	1,283
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		9.61					
16	NURSING FACILITY		36.83					
25	TOTAL		215.99					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							

GROUP(1) 1	M3PI REVENUE CODE 2	SERVICES PRIOR TO 10/1 RATE 3	10/1 DAYS 3.01	SERVICES ON/AFTER 10/1 RATE 4	10/1 DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE 4.02	9/30/01 DAYS 4.03
1	RUC		14				
2	RUB						
3	RUA						
3 .01	RUX						
3 .02	RUL						
4	RVC		1				
5	RVB		22				
6	RVA						
6 .01	RVX		7				
6 .02	RVL		7				
7	RHC		118				
8	RHB		25				
9	RHA		6				
9 .01	RHX						
9 .02	RHL						
10	RMC						
11	RMB		8				
12	RMA		31				
12 .01	RMX		283				
12 .02	RML		331				
13	RLB						
14	RLA						
14 .01	RLX						
15	SE3		768				
16	SE2		100				
17	SE1						
18	SSC						
19	SSB						
20	SSA		79				
21	CC2						
22	CC1						
23	CB2						
24	CB1						
25	CA2						
26	CA1						
27	IB2						
28	IB1						
29	IA2						
30	IA1						
31	BB2						
32	BB1						
33	BA2						
34	BA1						
35	PE2						
36	PE1						
37	PD2						
38	PD1						
39	PC2						
40	PC1						
41	PB2						
42	PB1						
43	PA2						
44	PA1						
45	AAA						
46	TOTAL		1,800				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01):	:	0.8335
Wage Index Factor (after 10/01):	:	0.8386
SNF Facility Specific Rate	:	0.00
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.05	4.06	5
1	RUC				
2	RUB				
3	RUA				
3 .01	RUX				
3 .02	RUL				
4	RVC				
5	RVB				
6	RVA				
6 .01	RVX				
6 .02	RVL				
7	RHC				
8	RHB				
9	RHA				
9 .01	RHX				
9 .02	RHL				
10	RMC				
11	RMB				
12	RMA				
12 .01	RMX				
12 .02	RML				
13	RLB				
14	RLA				
14 .01	RLX				
15	SE3				
16	SE2				
17	SE1				
18	SSC				
19	SSB				
20	SSA				
21	CC2				
22	CC1				
23	CB2				
24	CB1				
25	CA2				
26	CA1				
27	IB2				
28	IB1				
29	IA2				
30	IA1				
31	BB2				
32	BB1				
33	BA2				
34	BA1				
35	PE2				
36	PE1				
37	PD2				
38	PD1				
39	PC2				
40	PC1				
41	PB2				
42	PB1				
43	PA2				
44	PA1				
45	AAA				
46	TOTAL				

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01):	:	0.8335
Wage Index Factor (after 10/01):	:	0.8386
SNF Facility Specific Rate	:	0.00
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO:	I PERIOD:	I PREPARED 5/27/2009
I 14-1346	I FROM 1/ 1/2008	I WORKSHEET S-7
I	I TO 12/31/2008	I NOT A CMS WORKSHEET
		SERVICES THROUGH 12/31/2005

GROUP(1)		M3PI REVENUE CODE	SERVICES BASE RATE	PRIOR TO RATE	OCTOBER 1ST DAYS	SERVICES BASE RATE	ON OR AFTER RATE	OCTOBER 1ST DAYS
1			3a	3	3.01	4a	4	4.01
1	RUC		478.65	478.65	14	497.80		
2	RUB		442.78			460.49		
3	RUA		424.23			441.19		
3 .01	RUX		555.34			577.55		
3 .02	RUL		493.49			513.24		
4	RVC		378.00	378.00	1	393.12		
5	RVB		360.68	360.68	22	375.12		
6	RVA		327.29			340.39		
6 .01	RVX		416.34	416.34	7	433.00		
6 .02	RVL		390.37	390.37	7	405.99		
7	RHC		323.91	323.91	118	336.86		
8	RHB		310.31	310.31	25	322.72		
9	RHA		289.28	289.28	6	300.84		
9 .01	RHX		348.65			362.60		
9 .02	RHL		342.47			356.16		
10	RMC		296.13			307.99		
11	RMB		288.72	288.72	8	300.27		
12	RMA		282.53	282.53	31	293.84		
12 .01	RMX		392.62	392.62	283	408.32		
12 .02	RML		361.69	361.69	331	376.16		
13	RLB		256.66			266.93		
14	RLA		220.79			229.62		
14 .01	RLX		277.69			288.79		
15	SE3		311.09	311.09	768	323.53		
16	SE2		265.33	265.33	100	275.94		
17	SE1		236.87			246.34		
18	SSC		233.17			242.48		
19	SSB		220.79			229.62		
20	SSA		217.09	217.09	79	225.77		
21	CC2		231.93			241.20		
22	CC1		212.13			220.62		
23	CB2		202.24			210.32		
24	CB1		193.58			201.32		
25	CA2		192.34			200.03		
26	CA1		179.97			187.17		
27	IB2		172.55			179.45		
28	IB1		170.08			176.88		
29	IA2		156.47			162.73		
30	IA1		150.28			156.29		
31	BB2		171.32			178.17		
32	BB1		166.37			173.02		
33	BA2		155.24			161.44		
34	BA1		145.34			151.15		
35	PE2		186.16			193.60		
36	PE1		182.45			189.75		
37	PD2		177.50			184.60		
38	PD1		175.03			182.03		
39	PC2		168.85			175.59		
40	PC1		166.37			173.02		
41	PB2		149.05			155.01		
42	PB1		147.81			153.72		
43	PA2		146.57			152.43		
44	PA1		142.87			148.58		
45	AAA		142.87			148.58		
46	TOTAL				1,800			

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01):	:	0.8335
Wage Index Factor (after 10/01):	:	0.8386
SNF Facility Specific Rate	:	0.00
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

Non-CMS S-7 options selected:

[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2009
I 14-1346 I FROM 1/ 1/2008 I WORKSHEET S-7
I I TO 12/31/2008 I NOT A CMS WORKSHEET
SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	A I D S SERV PRIOR TO OCT. 1ST RATE	DIAGNOSIS DAYS	CODE 042 SERV ON/AFTER OCT. 1ST RATE	SWING BED SNF DAYS	TOTAL
1	RUC	1	4.02	4.03	4.04	4.05	4.06
2	RUB	2	1,091.32		1,134.98		5
3	RUA		1,009.54		1,049.92		6,701
3 .01	RUX		967.24		1,005.91		
3 .02	RUL		1,266.18		1,316.81		
4	RVC		1,125.16		1,170.19		
5	RVB		861.84		896.31		378
6	RVA		822.35		855.27		7,935
6 .01	RVX		746.22		776.09		
6 .02	RVL		949.26		987.24		2,914
7	RHC		890.04		925.66		2,733
8	RHB		738.51		768.04		38,221
9	RHA		707.51		735.80		7,758
9 .01	RHX		659.56		685.92		1,736
9 .02	RHL		794.92		826.73		
10	RMC		780.83		812.04		
11	RMB		675.18		702.22		
12	RMA		658.28		684.62		2,310
12 .01	RMX		644.17		669.96		8,758
12 .02	RML		895.17		930.97		111,111
13	RLB		824.65		857.64		119,719
14	RLA		585.18		608.60		
14 .01	RLX		503.40		523.53		
15	SE3		633.13		658.44		
16	SE2		709.29		737.65		238,917
17	SE1		604.95		629.14		26,533
18	SSC		540.06		561.66		
19	SSB		531.63		552.85		
20	SSA		503.40		523.53		
21	CC2		494.97		514.76		17,150
22	CC1		528.80		549.94		
23	CB2		483.66		503.01		
24	CB1		461.11		479.53		
25	CA2		441.36		459.01		
26	CA1		438.54		456.07		
27	IB2		410.33		426.75		
28	IB1		393.41		409.15		
29	IA2		387.78		403.29		
30	IA1		356.75		371.02		
31	BB2		342.64		356.34		
32	BB1		390.61		406.23		
33	BA2		379.32		394.49		
34	BA1		353.95		368.08		
35	PE2		331.38		344.62		
36	PE1		424.44		441.41		
37	PD2		415.99		432.63		
38	PD1		404.70		420.89		
39	PC2		399.07		415.03		
40	PC1		384.98		400.35		
41	PB2		379.32		394.49		
42	PB1		339.83		353.42		
43	PA2		337.01		350.48		
44	PA1		334.18		347.54		
45	AAA		325.74		338.76		
46	TOTAL		325.74		338.76		592,874

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

worksheet S-2 reference data:

Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8335
Wage Index Factor (after 10/01): 0.8386
SNF Facility Specific Rate : 0.00
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:

[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO:	I PERIOD:	I PREPARED 5/27/2009
I 14-1346	I FROM 1/ 1/2008	I WORKSHEET S-10
I	I TO 12/31/2008	I
I	I	I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION

- 1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?
- 2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER
LINES 2.01 THRU 2.04
 - 2.01 IS IT AT THE TIME OF ADMISSION?
 - 2.02 IS IT AT THE TIME OF FIRST BILLING?
 - 2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?
 - 2.04 OTHER METHODS OF WRITE-OFFS (SPEC.)
- 3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?
- 4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE
JUDGMENT WITHOUT FINANCIAL DATA?
- 5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?
- 6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS)
DATA?
- 7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET
WORTH DATA?
- 8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD
DEBT AND CHARITY CARE? IF YES ANSWER 8.01
 - 8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT
SERVICES?
- 9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN
YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04
 - 9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE
ELIGIBILITY?
 - 9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE
CHARITY FROM BAD DEBT?
 - 9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON
CHARITY DETERMINATION?
 - 9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE
DISTINCTION IMPORTANT?
- 10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,
WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS
(SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO
BE A CHARITY WRITE OFF?
- 11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,
IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY
LEVEL? IF YES ANSWER 11.01 THRU 11.04
 - 11.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL
POVERTY LEVEL?
 - 11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150%
OF THE FEDERAL POVERTY LEVEL?
 - 11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200%
OF THE FEDERAL POVERTY LEVEL?
 - 11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF
THE FEDERAL POVERTY LEVEL?
- 12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME
PATIENTS ON A GRADUAL SCALE?
- 13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH
PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY
MEDICAL EXPENSES?
- 14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED?
IF YES ANSWER LINES 14.01 AND 14.02
 - 14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT
GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING
COMPENSATED CARE?
 - 14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM
GOVERNMENT FUNDING?
- 15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE
TO CHARITY PATIENTS?
- 16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE
CHARITY CARE?

17	UNCOMPENSATED CARE REVENUES	
17.01	REVENUE FROM UNCOMPENSATED CARE	384,179
18	GROSS MEDICAID REVENUES	2,605,332
19	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
20	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
21	RESTRICTED GRANTS	
22	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,989,511

23	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.387197
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	

DESCRIPTION

27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	2,605,332
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	1,008,777
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	1,008,777
	(SUM OF LINES 25, 27, AND 29)	

I PROVIDER NO:

I PERIOD:

I PREPARED 5/27/2009

I 14-1346

I FROM 1/ 1/2008

I WORKSHEET A

I

I TO 12/31/2008

I

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		778,996	778,996	-560,769	218,227
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				421,736	421,736
5	0500 EMPLOYEE BENEFITS	91,511	1,921,265	2,012,776	12,589	2,025,365
6	0600 ADMINISTRATIVE & GENERAL	531,247	3,235,880	3,767,127	139,033	3,906,160
8	0800 OPERATION OF PLANT	224,335	82,041	306,376		306,376
8.01	0801 OPERATION OF PLANT HOSP ONLY		729,768	729,768		729,768
8.02	0802 OPERATION OF PLANT ANNEX ONLY		18,887	18,887		18,887
9	0900 LAUNDRY & LINEN SERVICE	73,752	77,983	151,735		151,735
10	1000 HOUSEKEEPING	335,155	100,749	435,904		435,904
11	1100 DIETARY	295,482	402,437	697,919	-241,291	456,628
12	1200 CAFETERIA				241,291	241,291
14	1400 NURSING ADMINISTRATION	348,292	29,961	378,253		378,253
15	1500 CENTRAL SERVICES & SUPPLY	60,888	79,678	140,566		140,566
16	1600 PHARMACY	65,489	343,753	409,242		409,242
17	1700 MEDICAL RECORDS & LIBRARY	285,717	128,974	414,691		414,691
20	2000 NONPHYSICIAN ANESTHETISTS				365,000	365,000
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,197,469	177,679	1,375,148		1,375,148
26	2600 INTENSIVE CARE UNIT	214,973	54,980	269,953		269,953
34	3400 SKILLED NURSING FACILITY	386,793	75,426	462,219	46,464	508,683
35	3500 NURSING FACILITY	1,250,985	344,614	1,595,599	-46,464	1,549,135
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	376,134	272,631	648,765		648,765
40	4000 ANESTHESIOLOGY		398,235	398,235	-365,000	33,235
41	4100 RADIOLOGY-DIAGNOSTIC	422,982	674,483	1,097,465		1,097,465
42	4200 RADIOLOGY-THERAPEUTIC		261,316	261,316		261,316
44	4400 LABORATORY	476,367	695,633	1,172,000		1,172,000
49	4900 RESPIRATORY THERAPY	275,068	308,782	583,850		583,850
50	5000 PHYSICAL THERAPY	388,813	46,280	435,093		435,093
52	5200 SPEECH PATHOLOGY	26,579	1,738	28,317		28,317
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		297,383	297,383		297,383
56	5600 DRUGS CHARGED TO PATIENTS		747,328	747,328		747,328
59	3160 OP PSYCH		597,315	597,315		597,315
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	299,189	1,064,076	1,363,265	276,877	1,640,142
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	6500 AMBULANCE SERVICES	350,478	95,636	446,114	-276,877	169,237
	SPEC PURPOSE COST CENTERS					
95	SUBTOTALS	7,977,698	14,043,907	22,021,605	12,589	22,034,194
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	941,900	141,462	1,083,362	-12,589	1,070,773
98.01	9801 FAYETTE COUNTY MEDICAL CENTER		53,560	53,560		53,560
98.02	9802 PUBLIC RELATIONS	28,046	79,582	107,628		107,628
98.03	9803 PERSONAL LAUNDRY					
98.04	9804 VIS MEALS & MEALS ON WHEELS					
101	TOTAL	8,947,644	14,318,511	23,266,155	-0-	23,266,155

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3 0300	NEW CAP REL COSTS-BLDG & FIXT	-3,273	214,954
4 0400	NEW CAP REL COSTS-MVBLE EQUIP		421,736
5 0500	EMPLOYEE BENEFITS	-4,430	2,020,935
6 0600	ADMINISTRATIVE & GENERAL	-65,912	3,840,248
8 0800	OPERATION OF PLANT	-3,171	303,205
8.01 0801	OPERATION OF PLANT HOSP ONLY		729,768
8.02 0802	OPERATION OF PLANT ANNEX ONLY		18,887
9 0900	LAUNDRY & LINEN SERVICE		151,735
10 1000	HOUSEKEEPING		435,904
11 1100	DIETARY	-53,549	403,079
12 1200	CAFETERIA		241,291
14 1400	NURSING ADMINISTRATION		378,253
15 1500	CENTRAL SERVICES & SUPPLY		140,566
16 1600	PHARMACY		409,242
17 1700	MEDICAL RECORDS & LIBRARY	-13,079	401,612
20 2000	NONPHYSICIAN ANESTHETISTS	-365,000	
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS		1,375,148
26 2600	INTENSIVE CARE UNIT		269,953
34 3400	SKILLED NURSING FACILITY		508,683
35 3500	NURSING FACILITY	-492,000	1,057,135
	ANCILLARY SRVC COST CNTRS		
37 3700	OPERATING ROOM		648,765
40 4000	ANESTHESIOLOGY		33,235
41 4100	RADIOLOGY-DIAGNOSTIC	-78	1,097,387
42 4200	RADIOLOGY-THERAPEUTIC		261,316
44 4400	LABORATORY	-27,083	1,144,917
49 4900	RESPIRATORY THERAPY		583,850
50 5000	PHYSICAL THERAPY		435,093
52 5200	SPEECH PATHOLOGY		28,317
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,312	296,071
56 5600	DRUGS CHARGED TO PATIENTS		747,328
59 3160	OP PSYCH		597,315
	OUTPAT SERVICE COST CNTRS		
61 6100	EMERGENCY	-807,734	832,408
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65 6500	AMBULANCE SERVICES		169,237
	SPEC PURPOSE COST CENTERS		
95	SUBTOTALS	-1,836,621	20,197,573
	NONREIMBURS COST CENTERS		
96 9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98 9800	PHYSICIANS' PRIVATE OFFICES		1,070,773
98.01 9801	FAYETTE COUNTY MEDICAL CENTER		53,560
98.02 9802	PUBLIC RELATIONS		107,628
98.03 9803	PERSONAL LAUNDRY		
98.04 9804	VIS MEALS & MEALS ON WHEELS		
101	TOTAL	-1,836,621	21,429,534

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT HOSP ONLY	0801	OPERATION OF PLANT
8.02	OPERATION OF PLANT ANNEX ONLY	0802	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
52	SPEECH PATHOLOGY	5200	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OP PSYCH	3160	CARDIOPULMONARY
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	FAYETTE COUNTY MEDICAL CENTER	9801	PHYSICIANS' PRIVATE OFFICES
98.02	PUBLIC RELATIONS	9802	PHYSICIANS' PRIVATE OFFICES
98.03	PERSONAL LAUNDRY	9803	PHYSICIANS' PRIVATE OFFICES
98.04	VIS MEALS & MEALS ON WHEELS	9804	PHYSICIANS' PRIVATE OFFICES
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:
141346PERIOD:
FROM 1/ 1/2008
TO 12/31/2008PREPARED 5/27/2009
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		SALARY	OTHER
	(1) 1	COST CENTER 2	LINE NO 3			
1 CAFETERIA	A	CAFETERIA	12		102,157	139,134
2 CRNA	B	NONPHYSICIAN ANESTHETISTS	20			365,000
3 NURSE ADMIN	C	SKILLED NURSING FACILITY	34		46,312	152
4 DEPRECIATION	D	NEW CAP REL COSTS-MVBLE EQUIP	4			421,736
5 ER IN AMBULANCE	E	EMERGENCY	61		276,877	
6 OPERATING INTEREST	F	ADMINISTRATIVE & GENERAL	6			110,658
7 OPERATING INSURANCE	G	ADMINISTRATIVE & GENERAL	6			28,375
8 EMP OCC HEALTH PROCEDURES	H	EMPLOYEE BENEFITS	5		8,716	3,873
36 TOTAL RECLASSIFICATIONS					434,062	1,068,928

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:

141346

PERIOD:

FROM 1/ 1/2008

TO 12/31/2008

PREPARED 5/27/2009

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	DECREASE					A-7 REF 10
	CODE (1) 1	COST CENTER 6	LINE NO 7	SALARY 8	OTHER 9	
1 CAFETERIA	A	DIETARY	11	102,157	139,134	
2 CRNA	B	ANESTHESIOLOGY	40		365,000	
3 NURSE ADMIN	C	NURSING FACILITY	35	46,312	152	
4 DEPRECIATION	D	NEW CAP REL COSTS-BLDG & FIXT	3		421,736	9
5 ER IN AMBULANCE	E	AMBULANCE SERVICES	65	276,877		
6 OPERATING INTEREST	F	NEW CAP REL COSTS-BLDG & FIXT	3		110,658	10
7 OPERATING INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		28,375	11
8 EMP OCC HEALTH PROCEDURES	H	PHYSICIANS' PRIVATE OFFICES	98	8,716	3,873	
36 TOTAL RECLASSIFICATIONS				434,062	1,068,928	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141346	FROM 1/ 1/2008	5/27/2009
	TO 12/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	241,291
TOTAL RECLASSIFICATIONS FOR CODE A		241,291

DECREASE		
COST CENTER	LINE	AMOUNT
DIETARY	11	241,291
		241,291

RECLASS CODE: B
EXPLANATION : CRNA

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NONPHYSICIAN ANESTHETISTS	365,000
TOTAL RECLASSIFICATIONS FOR CODE B		365,000

DECREASE		
COST CENTER	LINE	AMOUNT
ANESTHESIOLOGY	40	365,000
		365,000

RECLASS CODE: C
EXPLANATION : NURSE ADMIN

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	SKILLED NURSING FACILITY	46,464
TOTAL RECLASSIFICATIONS FOR CODE C		46,464

DECREASE		
COST CENTER	LINE	AMOUNT
NURSING FACILITY	35	46,464
		46,464

RECLASS CODE: D
EXPLANATION : DEPRECIATION

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	421,736
TOTAL RECLASSIFICATIONS FOR CODE D		421,736

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	421,736
		421,736

RECLASS CODE: E
EXPLANATION : ER IN AMBULANCE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	EMERGENCY	276,877
TOTAL RECLASSIFICATIONS FOR CODE E		276,877

DECREASE		
COST CENTER	LINE	AMOUNT
AMBULANCE SERVICES	65	276,877
		276,877

RECLASS CODE: F
EXPLANATION : OPERATING INTEREST

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	110,658
TOTAL RECLASSIFICATIONS FOR CODE F		110,658

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	110,658
		110,658

RECLASS CODE: G
EXPLANATION : OPERATING INSURANCE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	28,375
TOTAL RECLASSIFICATIONS FOR CODE G		28,375

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	28,375
		28,375

RECLASS CODE: H
EXPLANATION : EMP OCC HEALTH PROCEDURES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	EMPLOYEE BENEFITS	12,589
TOTAL RECLASSIFICATIONS FOR CODE H		12,589

DECREASE		
COST CENTER	LINE	AMOUNT
PHYSICIANS' PRIVATE OFFICES	98	12,589
		12,589

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES	PURCHASES	ACQUISITIONS DONATION	TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		1	2	3	4	5	6	7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	1,109,949					1,109,949	997,892
6	MOVABLE EQUIPMENT							
7	SUBTOTAL	1,109,949					1,109,949	997,892
8	RECONCILING ITEMS							
9	TOTAL	1,109,949					1,109,949	997,892

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL				TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	997,892		997,892	1.000000				
5	TOTAL	997,892		997,892	1.000000				

DESCRIPTION		SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	353,987	-110,658	-28,375				214,954
4	NEW CAP REL COSTS-MV	421,736						421,736
5	TOTAL	775,723	-110,658	-28,375				636,690

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION		SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	778,996						778,996
4	NEW CAP REL COSTS-MV							
5	TOTAL	778,996						778,996

(1) All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.
The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:
I 14-1346
II PERIOD: I PREPARED 5/27/2009
I FROM 1/ 1/2008 I WORKSHEET A-8
I TO 12/31/2008 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	WKST. A-7 REF. 5
	1	2	3	4	5
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES	B	-3,273	NEW CAP REL COSTS-BLDG &	3	9
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES	A	-4,372	ADMINISTRATIVE & GENERAL	6	
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-834,817			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-53,549	DIETARY	11	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-13,079	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES	B	-3,171	OPERATION OF PLANT	8	
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3		**COST CENTER DELETED**	71	
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST	A	-365,000	NONPHYSICIAN ANESTHETISTS	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 RECRUITMENT	A	-35,000	ADMINISTRATIVE & GENERAL	6	
37.01 MISCELLANEOUS REVENUE	B	-4,191	ADMINISTRATIVE & GENERAL	6	
37.02 NURSING HOME DISTRICT PAYMENT	B	-492,000	NURSING FACILITY	35	
37.03 AHA/IHA	A	-22,349	ADMINISTRATIVE & GENERAL	6	
37.04 EMPLOYEE BENEFIT OTHER REVENUE	B	-4,430	EMPLOYEE BENEFITS	5	
37.05					
37.06 CSS OTHER REVENUE	B	-1,312	MEDICAL SUPPLIES CHARGED	55	
37.07 RADIOLOGY OTHER REVENUE	B	-78	RADIOLOGY-DIAGNOSTIC	41	
37.08					
37.09					
37.10					
37.11					
37.12					
38 OTHER ADJUSTMENTS (SPECIFY)					
39 OTHER ADJUSTMENTS (SPECIFY)					
40 OTHER ADJUSTMENTS (SPECIFY)					
41 OTHER ADJUSTMENTS (SPECIFY)					
42 OTHER ADJUSTMENTS (SPECIFY)					
43 OTHER ADJUSTMENTS (SPECIFY)					
44 OTHER ADJUSTMENTS (SPECIFY)					
45 OTHER ADJUSTMENTS (SPECIFY)					
46 OTHER ADJUSTMENTS (SPECIFY)					
47 OTHER ADJUSTMENTS (SPECIFY)					
48 OTHER ADJUSTMENTS (SPECIFY)					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,836,621			

1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

ote: See instructions for column 5 referencing to worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	57,086	57,086	
2	41	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	28,046	28,046	
3	6	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	7,800	7,800	
4						
4.01						
4.02						
4.03						
4.04						
4.05						
4.06						
4.07						
4.08						
4.09						
4.10						
4.11						
4.12						
5		TOTALS	92,932	92,932		

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	ALLIANT MANAGEMENT		0.00	
2	B	BLUEGRASS LEASING		0.00	
3	B	ALLIANT PURCHASING		0.00	
4	B			0.00	
5	B			0.00	
5.01	B			0.00	
5.02	B			0.00	
5.03	B			0.00	
5.04	B			0.00	
5.05	B			0.00	

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
1	44	LABORATORY	27,083	27,083					
2	61	ER	989,930	807,734	182,196				
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
.01		TOTAL	1,017,013	834,817	182,196				

	WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
	10	11	12	13	14	15	16	17	18
1	44	LABORATORY							27,083
2	61	ER							807,734
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
01		TOTAL							834,817

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR	VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	6	SQ FT		ENTERED
8.01	OPERATION OF PLANT HOSP ONLY	7	SQ FT		ENTERED
8.02	OPERATION OF PLANT ANNEX ONLY	8	SQUARE FEET		ENTERED
9	LAUNDRY & LINEN SERVICE	9	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	11	MEALS	SERVED	ENTERED
12	CAFETERIA	12	NUMBER OF	FTE'S	ENTERED
14	NURSING ADMINISTRATION	14	NUMBER OF	FTE'S	ENTERED
15	CENTRAL SERVICES & SUPPLY	15	COSTED	REQUISITIONS	ENTERED
16	PHARMACY	16	COSTED	REQUISITIONS	ENTERED
17	MEDICAL RECORDS & LIBRARY	17	GROSS	REVENUES	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	ENTERED

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1997)			
COST ALLOCATION - GENERAL SERVICE COSTS			I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2009
			I	14-1346	I	FROM 1/ 1/2008	I	WORKSHEET B
			I		I	TO 12/31/2008	I	PART I
COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
		0	3	4	5	5a.00	6	8
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &	214,954	214,954					
005	NEW CAP REL COSTS-MVBLE E	421,736		421,736				
006	EMPLOYEE BENEFITS	2,020,935	8,904	11,226	2,041,065			
008	ADMINISTRATIVE & GENERAL	3,840,248	16,100	2,981	122,557	3,981,886	3,981,886	
008	OPERATION OF PLANT	303,205	23,742	14,534	51,753	393,234	89,743	482,977
008 01	OPERATION OF PLANT HOSP O	729,768				729,768	166,547	
008 02	OPERATION OF PLANT ANNEX	18,887				18,887	4,310	
009	LAUNDRY & LINEN SERVICE	151,735	3,958	436	17,014	173,143	39,515	13,269
010	HOUSEKEEPING	435,904	1,760	1,080	77,319	516,063	117,775	5,900
011	DIETARY	403,079	4,596	8,317	44,599	460,591	105,116	15,406
012	CAFETERIA	241,291	2,937		23,567	267,795	61,116	9,843
014	NURSING ADMINISTRATION	378,253	2,823	1,077	80,350	462,503	105,552	9,462
015	CENTRAL SERVICES & SUPPLY	140,566	1,277		14,047	155,890	35,577	4,281
016	PHARMACY	409,242	2,125	8,149	15,108	434,624	99,189	7,124
017	MEDICAL RECORDS & LIBRARY	401,612	4,222	32,702	65,914	504,450	115,125	14,154
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS	1,375,148	15,252	3,515	276,251	1,670,166	381,167	51,124
034	INTENSIVE CARE UNIT	269,953	2,741	16,395	49,593	338,682	77,294	9,189
035	SKILLED NURSING FACILITY	508,683	6,801		99,916	615,400	140,446	22,795
035	NURSING FACILITY	1,057,135	36,929	10,887	277,914	1,382,865	315,596	123,785
037	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM	648,765	11,751	72,278	86,773	819,567	187,041	39,388
041	ANESTHESIOLOGY	33,235				33,235	7,585	
042	RADIOLOGY-DIAGNOSTIC	1,097,387	9,651	139,981	97,580	1,344,599	306,863	32,351
044	RADIOLOGY-THERAPEUTIC	261,316				261,316	59,637	
049	LABORATORY	1,144,917	3,827	55,168	109,896	1,313,808	299,836	12,830
050	RESPIRATORY THERAPY	583,850	6,384	6,676	63,457	660,367	150,708	21,399
052	PHYSICAL THERAPY	435,093	13,451	5,366	89,698	543,608	124,062	45,087
055	SPEECH PATHOLOGY	28,317	404		6,132	34,853	7,954	1,353
056	MEDICAL SUPPLIES CHARGED	296,071				296,071	67,569	
059	DRUGS CHARGED TO PATIENTS	747,328				747,328	170,554	
061	OP PSYCH	597,315	2,233			599,548	136,828	7,483
062	OUTPAT SERVICE COST CNTRS							
065	EMERGENCY	832,408	7,852	24,346	132,896	997,502	227,649	26,321
095	OBSERVATION BEDS (NON-DIS							
096	OTHER REIMBURS COST CNTRS							
098	AMBULANCE SERVICES	169,237	2,067	2,689	16,979	190,972	43,583	6,929
098	SPEC PURPOSE COST CENTERS							
098	SUBTOTALS	20,197,573	191,787	417,803	1,819,313	19,948,721	3,643,937	479,473
098	NONREIMBURS COST CENTERS							
098	GIFT, FLOWER, COFFEE SHOP		1,045			1,045	238	3,504
098	PHYSICIANS' PRIVATE OFFIC	1,070,773	8,924	1,193	215,282	1,296,172	295,811	
098 01	FAYETTE COUNTY MEDICAL CE	53,560	13,198	2,740		69,498	15,861	
098 02	PUBLIC RELATIONS	107,628			6,470	114,098	26,039	
098 03	PERSONAL LAUNDRY							
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	21,429,534	214,954	421,736	2,041,065	21,429,534	3,981,886	482,977

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2009
 I 14-1346 I FROM 1/ 1/2008 I WORKSHEET B
 I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION		OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
		8.01	8.02	9	10	11	12	14
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008	01 OPERATION OF PLANT HOSP O	896,315						
008	02 OPERATION OF PLANT ANNEX		23,197					
009	LAUNDRY & LINEN SERVICE	31,517		257,444				
010	HOUSEKEEPING	14,015		18,217	671,970			
011	DIETARY	36,593		1,234	19,243	638,183		
012	CAFETERIA	23,381			12,296		374,431	
014	NURSING ADMINISTRATION	22,475			11,819		12,495	624,306
015	CENTRAL SERVICES & SUPPLY	10,169			5,348		6,546	
016	PHARMACY	16,921			8,898		4,516	
017	MEDICAL RECORDS & LIBRARY	33,619			17,679		14,478	
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	121,435		111,025	63,860	102,843	63,863	290,625
026	INTENSIVE CARE UNIT	21,826		330	11,478	7,266	16,676	75,891
034	SKILLED NURSING FACILITY	54,146			28,474	44,977	22,960	
035	NURSING FACILITY	6,307		91,381	154,621	453,550	87,992	
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	93,559		5,208	49,200		12,997	59,147
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	76,844		5,457	40,410		20,189	
042	RADIOLOGY-THERAPEUTIC							
044	LABORATORY	30,474		1	16,026		25,803	
049	RESPIRATORY THERAPY	50,830		36	26,730		12,041	
050	PHYSICAL THERAPY	107,096		161	56,319		14,431	
052	SPEECH PATHOLOGY	3,213			1,690		908	
055	MEDICAL SUPPLIES CHARGED							
056	DRUGS CHARGED TO PATIENTS							
059	OP PSYCH				9,348	29,547		
061	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	62,521		10,379	32,878		38,466	175,049
062	OBSERVATION BEDS (NON-DIS							
065	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES				8,655		5,185	23,594
065	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	816,941		243,429	574,972	638,183	359,546	624,306
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP	8,324			4,377			
098	PHYSICIANS' PRIVATE OFFIC	71,050		978	37,363		13,069	
098	01 FAYETTE COUNTY MEDICAL CE		23,197		55,258			
098	02 PUBLIC RELATIONS						1,816	
098	03 PERSONAL LAUNDRY			13,037				
098	04 VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	896,315	23,197	257,444	671,970	638,183	374,431	624,306

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1997)CONTD			
COST ALLOCATION - GENERAL SERVICE COSTS			I	PROVIDER NO:	I PERIOD:	I PREPARED 5/27/2009		
			I	14-1346	I FROM 1/ 1/2008	I WORKSHEET B		
			I		I TO 12/31/2008	I PART I		
	COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		15	16	17	20	25	26	27
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL CDSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008	01 OPERATION OF PLANT HOSP O							
008	02 OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA							
014	NURSING ADMINISTRATION							
015	CENTRAL SERVICES & SUPPLY	217,811						
016	PHARMACY		571,272					
017	MEDICAL RECORDS & LIBRARY			699,505				
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	12,256		37,934		2,906,298		2,906,298
026	INTENSIVE CARE UNIT	1,350		3,672		563,654		563,654
034	SKILLED NURSING FACILITY	4,304		4,070		937,572		937,572
035	NURSING FACILITY	18,321		42,267		2,676,685		2,676,685
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	41,305		13,698		1,321,110		1,321,110
040	ANESTHESIOLOGY	1,502		13,033		55,355		55,355
041	RADIOLOGY-DIAGNOSTIC	4,668		105,597		1,936,978		1,936,978
042	RADIOLOGY-THERAPEUTIC	51		15,256		336,260		336,260
044	LABORATORY	33,315		132,353		1,864,446		1,864,446
049	RESPIRATORY THERAPY	6,409		49,641		978,161		978,161
050	PHYSICAL THERAPY	930		17,479		909,173		909,173
052	SPEECH PATHOLOGY			1,194		51,165		51,165
055	MEDICAL SUPPLIES CHARGED	75,550		40,430		479,620		479,620
056	DRUGS CHARGED TO PATIENTS	6,731	571,272	109,299		1,605,184		1,605,184
059	OP PSYCH	65		20,545		803,364		803,364
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	6,884		52,226		1,629,875		1,629,875
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	1,350		18,124		298,392		298,392
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	214,991	571,272	676,818		19,353,292		19,353,292
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP					17,488		17,488
098	PHYSICIANS' PRIVATE OFFIC	2,820		22,687		1,763,147		1,763,147
098	01 FAYETTE COUNTY MEDICAL CE					140,617		140,617
098	02 PUBLIC RELATIONS					141,953		141,953
098	03 PERSONAL LAUNDRY					13,037		13,037
098	04 VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	217,811	571,272	699,505		21,429,534		21,429,534

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1996)			
ALLOCATION OF OLD CAPITAL RELATED COSTS					I PROVIDER NO:	I PERIOD:	I PREPARED	5/27/2009
					I 14-1346	I FROM 1/ 1/2008	I WORKSHEET B	
					I	I TO 12/31/2008	I PART II	
COST CENTER DESCRIPTION		DIR ASSIGNED OLD CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
		0	3	4	4a	5	6	8
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL	67			67		67	
008	OPERATION OF PLANT						2	2
008 01	OPERATION OF PLANT HOSP O						3	
008 02	OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE						1	
010	HOUSEKEEPING						2	
011	DIETARY						2	
012	CAFETERIA						1	
014	NURSING ADMINISTRATION						2	
015	CENTRAL SERVICES & SUPPLY						1	
016	PHARMACY						2	
017	MEDICAL RECORDS & LIBRARY						2	
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS						5	
026	INTENSIVE CARE UNIT						1	
034	SKILLED NURSING FACILITY						2	
035	NURSING FACILITY						6	2
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM						3	
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC						5	
042	RADIOLOGY-THERAPEUTIC						1	
044	LABORATORY						5	
049	RESPIRATORY THERAPY						3	
050	PHYSICAL THERAPY						2	
052	SPEECH PATHOLOGY							
055	MEDICAL SUPPLIES CHARGED						1	
056	DRUGS CHARGED TO PATIENTS						3	
059	OP PSYCH						2	
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY						4	
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES						1	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	67			67		62	2
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC						5	
098 01	FAYETTE COUNTY MEDICAL CE							
098 02	PUBLIC RELATIONS							
098 03	PERSONAL LAUNDRY							
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	67			67		67	2

COST CENTER DESCRIPTION		OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
		8.01	8.02	9	10	11	12	14
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008 01	OPERATION OF PLANT HOSP O	3						
008 02	OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE			1				
010	HOUSEKEEPING				2			
011	DIETARY					2		
012	CAFETERIA						1	
014	NURSING ADMINISTRATION							2
015	CENTRAL SERVICES & SUPPLY							
016	PHARMACY							
017	MEDICAL RECORDS & LIBRARY							
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	3		1				1
026	INTENSIVE CARE UNIT							
034	SKILLED NURSING FACILITY							
035	NURSING FACILITY				2	2	1	
037	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM							
041	ANESTHESIOLOGY							
042	RADIOLOGY-DIAGNOSTIC							
044	RADIOLOGY-THERAPEUTIC							
049	LABORATORY							
050	RESPIRATORY THERAPY							
052	PHYSICAL THERAPY							
055	SPEECH PATHOLOGY							
056	MEDICAL SUPPLIES CHARGED							
059	DRUGS CHARGED TO PATIENTS							
061	OP PSYCH							
062	OUTPAT SERVICE COST CNTRS							
062	EMERGENCY							1
065	OBSERVATION BEDS (NON-DIS							
065	OTHER REIMBURS COST CNTRS							
095	AMBULANCE SERVICES							
095	SPEC PURPOSE COST CENTERS	3		1	2	2	1	2
096	SUBTOTALS							
098	NONREIMBURS COST CENTERS							
098	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC							
098 01	FAYETTE COUNTY MEDICAL CE							
098 02	PUBLIC RELATIONS							
098 03	PERSONAL LAUNDRY							
098 04	VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	3		1	2	2	1	2

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1996)CONTD			
ALLOCATION OF OLD CAPITAL RELATED COSTS					I PROVIDER NO:	I PERIOD:	I PREPARED	5/27/2009
					I 14-1346	I FROM 1/ 1/2008	I WORKSHEET B	
					I	I TO 12/31/2008	I PART II	
COST CENTER DESCRIPTION		CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	SUBTOTAL		POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	25		26	27
GENERAL SERVICE COST CNTR								
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008	01 OPERATION OF PLANT HOSP O							
008	02 OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA							
014	NURSING ADMINISTRATION							
015	CENTRAL SERVICES & SUPPLY	1						
016	PHARMACY		2					
017	MEDICAL RECORDS & LIBRARY			2				
020	NONPHYSICIAN ANESTHETISTS							
INPAT ROUTINE SRVC CNTRS								
025	ADULTS & PEDIATRICS				10			10
026	INTENSIVE CARE UNIT				1			1
034	SKILLED NURSING FACILITY				2			2
035	NURSING FACILITY				13			13
ANCILLARY SRVC COST CNTRS								
037	OPERATING ROOM				3			3
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC				5			5
042	RADIOLOGY-THERAPEUTIC				1			1
044	LABORATORY			2	7			7
049	RESPIRATORY THERAPY				3			3
050	PHYSICAL THERAPY				2			2
052	SPEECH PATHOLOGY							
055	MEDICAL SUPPLIES CHARGED	1			2			2
056	DRUGS CHARGED TO PATIENTS		2		5			5
059	OP PSYCH				2			2
OUTPAT SERVICE COST CNTRS								
061	EMERGENCY				5			5
062	OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS								
065	AMBULANCE SERVICES				1			1
SPEC PURPOSE COST CENTERS								
095	SUBTOTALS	1	2	2	62			62
NONREIMBURS COST CENTERS								
096	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC				5			5
098	01 FAYETTE COUNTY MEDICAL CE							
098	02 PUBLIC RELATIONS							
098	03 PERSONAL LAUNDRY							
098	04 VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	1	2	2	67			67

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1996)		
ALLOCATION OF NEW CAPITAL RELATED COSTS			I	PROVIDER NO:	I PERIOD:	I	PREPARED 5/27/2009
			I	14-1346	I FROM 1/ 1/2008	I	WORKSHEET B
			I		I TO 12/31/2008	I	PART III
COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	0	3	4		5	6	8
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS	1,238	8,904	11,226	21,368	21,368		
008 ADMINISTRATIVE & GENERAL	153,764	16,100	2,981	172,845	1,283	174,128	
008 OPERATION OF PLANT	3,170	23,742	14,534	41,446	542	3,924	45,912
008 01 OPERATION OF PLANT HOSP O						7,283	
008 02 OPERATION OF PLANT ANNEX						188	
009 LAUNDRY & LINEN SERVICE		3,958	436	4,394	178	1,728	1,261
010 HOUSEKEEPING		1,760	1,080	2,840	809	5,150	561
011 DIETARY	707	4,596	8,317	13,620	467	4,597	1,464
012 CAFETERIA		2,937		2,937	247	2,673	936
014 NURSING ADMINISTRATION	2,710	2,823	1,077	6,610	841	4,616	899
015 CENTRAL SERVICES & SUPPLY	17,704	1,277		18,981	147	1,556	407
016 PHARMACY	51,960	2,125	8,149	62,234	158	4,338	677
017 MEDICAL RECORDS & LIBRARY	1,459	4,222	32,702	38,383	690	5,034	1,345
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		15,252	3,515	18,767	2,892	16,669	4,860
034 INTENSIVE CARE UNIT		2,741	16,395	19,136	519	3,380	873
035 SKILLED NURSING FACILITY		6,801		6,801	1,046	6,142	2,167
037 NURSING FACILITY		36,929	10,887	47,816	2,911	13,801	11,769
040 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM		11,751	72,278	84,029	908	8,179	3,744
041 ANESTHESIOLOGY						332	
041 RADIOLOGY-DIAGNOSTIC	1,718	9,651	139,981	151,350	1,022	13,419	3,075
042 RADIOLOGY-THERAPEUTIC						2,608	
044 LABORATORY	2,034	3,827	55,168	61,029	1,150	13,112	1,220
049 RESPIRATORY THERAPY	14,120	6,384	6,676	27,180	664	6,590	2,034
050 PHYSICAL THERAPY		13,451	5,366	18,817	939	5,425	4,286
052 SPEECH PATHOLOGY		404		404	64	348	129
055 MEDICAL SUPPLIES CHARGED						2,955	
056 DRUGS CHARGED TO PATIENTS						7,458	
059 OP PSYCH	1,441	2,233		3,674		5,983	711
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	1,459	7,852	24,346	33,657	1,391	9,955	2,502
065 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS		2,067	2,689	4,756	178	1,906	659
095 AMBULANCE SERVICES							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	253,484	191,787	417,803	863,074	19,046	159,349	45,579
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		1,045		1,045		10	333
098 PHYSICIANS' PRIVATE OFFIC		8,924	1,193	10,117	2,254	12,936	
098 01 FAYETTE COUNTY MEDICAL CE		13,198	2,740	15,938		694	
098 02 PUBLIC RELATIONS					68	1,139	
098 03 PERSONAL LAUNDRY							
098 04 VIS MEALS & MEALS ON WHEE							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	253,484	214,954	421,736	890,174	21,368	174,128	45,912

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/27/2009
 I 14-1346 I FROM 1/ 1/2008 I WORKSHEET B
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION		OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
		8.01	8.02	9	10	11	12	14
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
008	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008	01 OPERATION OF PLANT HOSP O	7,283						
008	02 OPERATION OF PLANT ANNEX		188					
009	LAUNDRY & LINEN SERVICE	256		7,817				
010	HOUSEKEEPING	114		553	10,027			
011	DIETARY	297		37	287	20,769		
012	CAFETERIA	190			183		7,166	
014	NURSING ADMINISTRATION	183			176		239	13,564
015	CENTRAL SERVICES & SUPPLY	83			80		125	
016	PHARMACY	137			133		86	
017	MEDICAL RECORDS & LIBRARY	273			264		277	
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	988		3,371	953	3,347	1,222	6,314
026	INTENSIVE CARE UNIT	177		10	171	236	319	1,649
034	SKILLED NURSING FACILITY	440			425	1,464	439	
035	NURSING FACILITY	51		2,775	2,308	14,760	1,687	
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	760		158	734		249	1,285
040	ANESTHESIOLOGY							
041	RADIOLOGY-DIAGNOSTIC	624		166	603		386	
042	RADIOLOGY-THERAPEUTIC							
044	LABORATORY	248			239		494	
049	RESPIRATORY THERAPY	413		1	399		230	
050	PHYSICAL THERAPY	870		5	840		276	
052	SPEECH PATHOLOGY	26			25		17	
055	MEDICAL SUPPLIES CHARGED							
056	DRUGS CHARGED TO PATIENTS							
059	OP PSYCH				139	962		
061	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	508		315	491		736	3,803
062	OBSERVATION BEDS (NON-DIS							
065	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES				129		99	513
095	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	6,638		7,391	8,579	20,769	6,881	13,564
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP	68			65			
098	PHYSICIANS' PRIVATE OFFIC	577		30	558		250	
098	01 FAYETTE COUNTY MEDICAL CE		188		825			
098	02 PUBLIC RELATIONS						35	
098	03 PERSONAL LAUNDRY			396				
098	04 VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	7,283	188	7,817	10,027	20,769	7,166	13,564

Health Financial Systems		MCRIF32	FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1996)CONTD			
ALLOCATION OF NEW CAPITAL RELATED COSTS					I PROVIDER NO: I 14-1346 I	I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008	I PREPARED 5/27/2009 I WORKSHEET B I PART III	
	COST CENTER DESCRIPTION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		15	16	17	20	25	26	27
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
008	01 OPERATION OF PLANT HOSP D							
008	02 OPERATION OF PLANT ANNEX							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA							
014	NURSING ADMINISTRATION							
015	CENTRAL SERVICES & SUPPLY	21,379						
016	PHARMACY		67,763					
017	MEDICAL RECORDS & LIBRARY			46,266				
020	NONPHYSICIAN ANESTHETISTS							
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	1,203		2,509		63,095		63,095
026	INTENSIVE CARE UNIT	133		243		26,846		26,846
034	SKILLED NURSING FACILITY	422		269		19,615		19,615
035	NURSING FACILITY	1,798		2,795		102,471		102,471
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	4,054		906		105,006		105,006
040	ANESTHESIOLOGY	147		862		1,341		1,341
041	RADIOLOGY-DIAGNOSTIC	458		6,984		178,087		178,087
042	RADIOLOGY-THERAPEUTIC	5		1,009		3,622		3,622
044	LABORATORY	3,270		8,756		89,518		89,518
049	RESPIRATORY THERAPY	629		3,283		41,423		41,423
050	PHYSICAL THERAPY	91		1,156		32,705		32,705
052	SPEECH PATHOLOGY			79		1,092		1,092
055	MEDICAL SUPPLIES CHARGED	7,416		2,674		13,045		13,045
056	DRUGS CHARGED TO PATIENTS	661	67,763	7,229		83,111		83,111
059	OP PSYCH	6		1,359		12,834		12,834
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	676		3,454		57,488		57,488
062	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES	133		1,199		9,572		9,572
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	21,102	67,763	44,766		840,871		840,871
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP					1,521		1,521
098	PHYSICIANS' PRIVATE OFFIC	277		1,500		28,687		28,687
098	01 FAYETTE COUNTY MEDICAL CE					17,457		17,457
098	02 PUBLIC RELATIONS					1,242		1,242
098	03 PERSONAL LAUNDRY					396		396
098	04 VIS MEALS & MEALS ON WHEE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	21,379	67,763	46,266		890,174		890,174

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCIL- IATION	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT
	OSTS-BLDG & (SQUARE FEET	OSTS-MVBLE (DOLLAR)VALUE	E FITS (GROSS SALARIES)		(ACCUM. COST)	(SQ FT)
	3	4	5	6a.00	6	8
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	100,135					
005 NEW CAP REL COSTS-MVB		498,821				
006 EMPLOYEE BENEFITS	4,148	13,278	8,847,417			
008 ADMINISTRATIVE & GENE	7,500	3,526	531,247	-3,981,886	17,447,648	
008 OPERATION OF PLANT	11,060	17,191	224,335		393,234	67,122
008 01 OPERATION OF PLANT HO					729,768	
008 02 OPERATION OF PLANT AN					18,887	
009 LAUNDRY & LINEN SERVI	1,844	516	73,752		173,143	1,844
010 HOUSEKEEPING	820	1,277	335,155		516,063	820
011 DIETARY	2,141	9,837	193,325		460,591	2,141
012 CAFETERIA	1,368		102,157		267,795	1,368
014 NURSING ADMINISTRATIO	1,315	1,274	348,292		462,503	1,315
015 CENTRAL SERVICES & SU	595		60,888		155,890	595
016 PHARMACY	990	9,639	65,489		434,624	990
017 MEDICAL RECORDS & LIB	1,967	38,679	285,717		504,450	1,967
020 NONPHYSICIAN ANESTHET						
025 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	7,105	4,157	1,197,469		1,670,166	7,105
034 INTENSIVE CARE UNIT	1,277	19,392	214,973		338,682	1,277
035 SKILLED NURSING FACIL	3,168		433,105		615,400	3,168
037 NURSING FACILITY	17,203	12,877	1,204,673		1,382,865	17,203
040 ANCILLARY SRVC COST C						
041 OPERATING ROOM	5,474	85,489	376,134		819,567	5,474
042 ANESTHESIOLOGY					33,235	
044 RADIOLOGY-DIAGNOSTIC	4,496	165,565	422,982		1,344,599	4,496
049 RADIOLOGY-THERAPEUTIC					261,316	
050 LABORATORY	1,783	65,252	476,367		1,313,808	1,783
052 RESPIRATORY THERAPY	2,974	7,896	275,068		660,367	2,974
055 PHYSICAL THERAPY	6,266	6,347	388,813		543,608	6,266
056 SPEECH PATHOLOGY	188		26,579		34,853	188
059 MEDICAL SUPPLIES CHAR					296,071	
061 DRUGS CHARGED TO PATI					747,328	
062 OP PSYCH	1,040				599,548	1,040
065 OUTPAT SERVICE COST C						
066 EMERGENCY	3,658	28,796	576,066		997,502	3,658
065 OBSERVATION BEDS (NON						
095 OTHER REIMBURS COST C						
096 AMBULANCE SERVICES	963	3,181	73,601		190,972	963
098 SPEC PURPOSE COST CEN						
098 SUBTOTALS	89,343	494,169	7,886,187	-3,981,886	15,966,835	66,635
098 NONREIMBURS COST CENT						
098 GIFT, FLOWER, COFFEE	487				1,045	487
098 PHYSICIANS' PRIVATE O	4,157	1,411	933,184		1,296,172	
098 01 FAYETTE COUNTY MEDICA	6,148	3,241			69,498	
098 02 PUBLIC RELATIONS			28,046		114,098	
098 03 PERSONAL LAUNDRY						
098 04 VIS MEALS & MEALS ON						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	214,954	421,736	2,041,065		3,981,886	482,977
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	2.146642		.230696		.228219	
105 (WRKSHT B, PT I)		.845466				7.195510
105 COST TO BE ALLOCATED					67	2
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER					.000004	
107 (WRKSHT B, PT II)						.000030
107 COST TO BE ALLOCATED			21,368		174,128	45,912
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.002415		.009980	
108 (WRKSHT B, PT III)						.684008

COST CENTER DESCRIPTION	OPERATION OF PLANT HOSP O	OPERATION OF PLANT ANNEX	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION
	(SQ FT	(SQUARE FEET	(POUNDS OF	(SQUARE	(MEALS	S(NUMBER OF	(NUMBER OF
))	LAUNDRY) FEET	ERVED) FTE'S) FTE'S
	8.01	8.02	9	10	11	12	14
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
008 ADMINISTRATIVE & GENE							
008 OPERATION OF PLANT							
008 01 OPERATION OF PLANT HO	52,442						
008 02 OPERATION OF PLANT AN		2,131					
009 LAUNDRY & LINEN SERVI	1,844		578,060				
010 HOUSEKEEPING	820		40,903	74,763			
011 DIETARY	2,141		2,771	2,141	96,699		
012 CAFETERIA	1,368			1,368		15,672	
014 NURSING ADMINISTRATIO	1,315			1,315		523	5,742
015 CENTRAL SERVICES & SU	595			595		274	
016 PHARMACY	990			990		189	
017 MEDICAL RECORDS & LIB	1,967			1,967		606	
020 NONPHYSICIAN ANESTHET							
INPAT ROUTINE SRVC CN							
025 ADULTS & PEDIATRICS	7,105		249,294	7,105	15,583	2,673	2,673
026 INTENSIVE CARE UNIT	1,277		740	1,277	1,101	698	698
034 SKILLED NURSING FACIL	3,168			3,168	6,815	961	
035 NURSING FACILITY	369		205,184	17,203	68,723	3,683	
ANCILLARY SRVC COST C							
037 OPERATING ROOM	5,474		11,695	5,474		544	544
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	4,496		12,253	4,496		845	
042 RADIOLOGY-THERAPEUTIC							
044 LABORATORY	1,783		2	1,783		1,080	
049 RESPIRATORY THERAPY	2,974		81	2,974		504	
050 PHYSICAL THERAPY	6,266		361	6,266		604	
052 SPEECH PATHOLOGY	188			188		38	
055 MEDICAL SUPPLIES CHAR							
056 DRUGS CHARGED TO PATI							
059 OP PSYCH				1,040	4,477		
OUTPAT SERVICE COST C							
061 EMERGENCY	3,658		23,305	3,658		1,610	1,610
062 OBSERVATION BEDS (NON							
OTHER REIMBURS COST C							
065 AMBULANCE SERVICES				963		217	217
SPEC PURPOSE COST CEN							
095 SUBTOTALS	47,798		546,589	63,971	96,699	15,049	5,742
NONREIMBURS COST CENT							
096 GIFT, FLOWER, COFFEE	487			487			
098 PHYSICIANS' PRIVATE O	4,157	2,131	2,197	4,157		547	
098 01 FAYETTE COUNTY MEDICA				6,148			
098 02 PUBLIC RELATIONS						76	
098 03 PERSONAL LAUNDRY			29,274				
098 04 VIS MEALS & MEALS ON							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	896,315	23,197	257,444	671,970	638,183	374,431	624,306
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER		10.885500		8.988002		23.891718	
(WRKSHT B, PT I)	17.091549		.445359		6.599686		108.726228
105 COST TO BE ALLOCATED	3		1	2	2	1	2
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER				.000027		.000064	
(WRKSHT B, PT II)	.000057		.000002		.000021		.000348
107 COST TO BE ALLOCATED	7,283	188	7,817	10,027	20,769	7,166	13,564
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER		.088221		.134117		.457249	
(WRKSHT B, PT III)	.138877		.013523		.214780		2.362243

Health Financial Systems		MCRIF32		FOR FAYETTE COUNTY HOSPITAL		IN LIEU OF FORM CMS-2552-96(9/1997)CONTD			
COST ALLOCATION - STATISTICAL BASIS				I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2009
				I	14-1346	I	FROM 1/ 1/2008	I	WORKSHEET B-1
				I		I	TO 12/31/2008	I	
COST CENTER DESCRIPTION		CENTRAL SERVI PHARMACY CES & SUPPLY		MEDICAL RECOR NONPHYSICIAN DS & LIBRARY ANESTHETISTS					
		(COSTED ISITIONS	REQU(COSTED)ISITIONS	REQU(GROSS)REVENUES	(ASSIGNED) TIME				
		15	16	17	20				
GENERAL SERVICE COST									
003	NEW CAP REL COSTS-BLD								
004	NEW CAP REL COSTS-MVB								
005	EMPLOYEE BENEFITS								
006	ADMINISTRATIVE & GENE								
008	OPERATION OF PLANT								
008	01 OPERATION OF PLANT HO								
008	02 OPERATION OF PLANT AN								
009	LAUNDRY & LINEN SERVI								
010	HOUSEKEEPING								
011	DIETARY								
012	CAFETERIA								
014	NURSING ADMINISTRATIO								
015	CENTRAL SERVICES & SU	857,388							
016	PHARMACY		100						
017	MEDICAL RECORDS & LIB			52,453,180					
020	NONPHYSICIAN ANESTHET				100				
	INPAT ROUTINE SRVC CN								
025	ADULTS & PEDIATRICS	48,246		2,844,514					
026	INTENSIVE CARE UNIT	5,316		275,376					
034	SKILLED NURSING FACIL	16,944		305,181					
035	NURSING FACILITY	72,120		3,169,388					
	ANCILLARY SRVC COST C								
037	OPERATING ROOM	162,594		1,027,142					
040	ANESTHESIOLOGY	5,913		977,281	100				
041	RADIOLOGY-DIAGNOSTIC	18,377		7,918,205					
042	RADIOLOGY-THERAPEUTIC	202		1,144,001					
044	LABORATORY	131,141		9,925,195					
049	RESPIRATORY THERAPY	25,229		3,722,366					
050	PHYSICAL THERAPY	3,659		1,310,689					
052	SPEECH PATHOLOGY			89,539					
055	MEDICAL SUPPLIES CHAR	297,383		3,031,631					
056	DRUGS CHARGED TO PATI	26,496	100	8,195,752					
059	OP PSYCH	254		1,540,591					
	OUTPAT SERVICE COST C								
061	EMERGENCY	27,099		3,916,136					
062	OBSERVATION BEDS (NON								
	OTHER REIMBURS COST C								
065	AMBULANCE SERVICES	5,316		1,359,024					
	SPEC PURPOSE COST CEN								
095	SUBTOTALS	846,289	100	50,752,011	100				
	NONREIMBURS COST CENT								
096	GIFT, FLOWER, COFFEE								
098	PHYSICIANS' PRIVATE O	11,099		1,701,169					
098	01 FAYETTE COUNTY MEDICA								
098	02 PUBLIC RELATIONS								
098	03 PERSONAL LAUNDRY								
098	04 VIS MEALS & MEALS ON								
101	CROSS FOOT ADJUSTMENT								
102	NEGATIVE COST CENTER								
103	COST TO BE ALLOCATED	217,811	571,272	699,505					
	(PER WRKSHT B, PART								
104	UNIT COST MULTIPLIER		5,712.720000						
	(WRKSHT B, PT I)	.254040		.013336					
105	COST TO BE ALLOCATED	1	2	2					
	(PER WRKSHT B, PART								
106	UNIT COST MULTIPLIER		.020000						
	(WRKSHT B, PT II)	.000001							
107	COST TO BE ALLOCATED	21,379	67,763	46,266					
	(PER WRKSHT B, PART								
108	UNIT COST MULTIPLIER		677.630000						
	(WRKSHT B, PT III)	.024935		.000882					

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
26	ADULTS & PEDIATRICS	2,906,298		2,906,298		2,906,298
34	INTENSIVE CARE UNIT	563,654		563,654		563,654
35	SKILLED NURSING FACILITY	937,572		937,572		937,572
	NURSING FACILITY	2,676,685		2,676,685		2,676,685
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,321,110		1,321,110		1,321,110
40	ANESTHESIOLOGY	55,355		55,355		55,355
41	RADIOLOGY-DIAGNOSTIC	1,936,978		1,936,978		1,936,978
42	RADIOLOGY-THERAPEUTIC	336,260		336,260		336,260
44	LABORATORY	1,864,446		1,864,446		1,864,446
49	RESPIRATORY THERAPY	978,161		978,161		978,161
50	PHYSICAL THERAPY	909,173		909,173		909,173
52	SPEECH PATHOLOGY	51,165		51,165		51,165
55	MEDICAL SUPPLIES CHARGED	479,620		479,620		479,620
56	DRUGS CHARGED TO PATIENTS	1,605,184		1,605,184		1,605,184
59	OP PSYCH	803,364		803,364		803,364
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,629,875		1,629,875		1,629,875
62	OBSERVATION BEDS (NON-DIS	258,770		258,770		258,770
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	298,392		298,392		298,392
101	SUBTOTAL	19,612,062		19,612,062		19,612,062
102	LESS OBSERVATION BEDS	258,770		258,770		258,770
103	TOTAL	19,353,292		19,353,292		19,353,292

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,564,551		2,564,551			
26	INTENSIVE CARE UNIT	275,376		275,376			
34	SKILLED NURSING FACILITY	305,181		305,181			
35	NURSING FACILITY	3,169,388		3,169,388			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	188,295	838,847	1,027,142	1.286200	1.286200	1.286200
40	ANESTHESIOLOGY	34,225	309,986	344,211	.160817	.160817	.160817
41	RADIOLOGY-DIAGNOSTIC	1,105,208	6,812,997	7,918,205	.244623	.244623	.244623
42	RADIOLOGY-THERAPEUTIC	101,214	1,042,787	1,144,001	.293933	.293933	.293933
44	LABORATORY	2,461,388	7,463,807	9,925,195	.187850	.187850	.187850
49	RESPIRATORY THERAPY	1,403,470	1,186,634	2,590,104	.377653	.377653	.377653
50	PHYSICAL THERAPY	333,887	976,802	1,310,689	.693660	.693660	.693660
52	SPEECH PATHOLOGY	55,711	33,828	89,539	.571427	.571427	.571427
55	MEDICAL SUPPLIES CHARGED	2,095,927	1,932,143	4,028,070	.119069	.119069	.119069
56	DRUGS CHARGED TO PATIENTS	6,155,433	2,040,320	8,195,753	.195856	.195856	.195856
59	OP PSYCH		1,540,591	1,540,591	.521465	.521465	.521465
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	160,931	3,755,205	3,916,136	.416195	.416195	.416195
62	OBSERVATION BEDS (NON-DIS	29,166	250,797	279,963	.924301	.924301	.924301
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,359,024	1,359,024	.219563	.219563	.219563
101	SUBTOTAL	20,439,351	29,543,768	49,983,119			
102	LESS OBSERVATION BEDS						
103	TOTAL	20,439,351	29,543,768	49,983,119			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,906,298		2,906,298		2,906,298
26	INTENSIVE CARE UNIT	563,654		563,654		563,654
34	SKILLED NURSING FACILITY	937,572		937,572		937,572
35	NURSING FACILITY	2,676,685		2,676,685		2,676,685
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,321,110		1,321,110		1,321,110
40	ANESTHESIOLOGY	55,355		55,355		55,355
41	RADIOLOGY-DIAGNOSTIC	1,936,978		1,936,978		1,936,978
42	RADIOLOGY-THERAPEUTIC	336,260		336,260		336,260
44	LABORATORY	1,864,446		1,864,446		1,864,446
49	RESPIRATORY THERAPY	978,161		978,161		978,161
50	PHYSICAL THERAPY	909,173		909,173		909,173
52	SPEECH PATHOLOGY	51,165		51,165		51,165
55	MEDICAL SUPPLIES CHARGED	479,620		479,620		479,620
56	DRUGS CHARGED TO PATIENTS	1,605,184		1,605,184		1,605,184
59	OP PSYCH	803,364		803,364		803,364
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,629,875		1,629,875		1,629,875
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	258,770		258,770		258,770
65	AMBULANCE SERVICES	298,392		298,392		298,392
101	SUBTOTAL	19,612,062		19,612,062		19,612,062
102	LESS OBSERVATION BEDS	258,770		258,770		258,770
103	TOTAL	19,353,292		19,353,292		19,353,292

WKST A LINE NO.	CDST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,564,551		2,564,551			
26	INTENSIVE CARE UNIT	275,376		275,376			
34	SKILLED NURSING FACILITY	305,181		305,181			
35	NURSING FACILITY	3,169,388		3,169,388			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	188,295	838,847	1,027,142	1.286200	1.286200	1.286200
40	ANESTHESIOLOGY	34,225	309,986	344,211	.160817	.160817	.160817
41	RADIOLOGY-DIAGNOSTIC	1,105,208	6,812,997	7,918,205	.244623	.244623	.244623
42	RADIOLOGY-THERAPEUTIC	101,214	1,042,787	1,144,001	.293933	.293933	.293933
44	LABORATORY	2,461,388	7,463,807	9,925,195	.187850	.187850	.187850
49	RESPIRATORY THERAPY	1,403,470	1,186,634	2,590,104	.377653	.377653	.377653
50	PHYSICAL THERAPY	333,887	976,802	1,310,689	.693660	.693660	.693660
52	SPEECH PATHOLOGY	55,711	33,828	89,539	.571427	.571427	.571427
55	MEDICAL SUPPLIES CHARGED	2,095,927	1,932,143	4,028,070	.119069	.119069	.119069
56	DRUGS CHARGED TO PATIENTS	6,155,433	2,040,320	8,195,753	.195856	.195856	.195856
59	OP PSYCH		1,540,591	1,540,591	.521465	.521465	.521465
	OUTPAT SERVICE CDST CNTRS						
61	EMERGENCY	160,931	3,755,205	3,916,136	.416195	.416195	.416195
62	OBSERVATION BEDS (NON-DIS	29,166	250,797	279,963	.924301	.924301	.924301
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		1,359,024	1,359,024	.219563	.219563	.219563
101	SUBTOTAL	20,439,351	29,543,768	49,983,119			
102	LESS OBSERVATION BEDS						
103	TOTAL	20,439,351	29,543,768	49,983,119			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,321,110	105,009	1,216,101			1,321,110
41	ANESTHESIOLOGY	55,355	1,341	54,014			55,355
42	RADIOLOGY-DIAGNOSTIC	1,936,978	178,092	1,758,886			1,936,978
44	RADIOLOGY-THERAPEUTIC	336,260	3,623	332,637			336,260
49	LABORATORY	1,864,446	89,525	1,774,921			1,864,446
50	RESPIRATORY THERAPY	978,161	41,426	936,735			978,161
52	PHYSICAL THERAPY	909,173	32,707	876,466			909,173
55	SPEECH PATHOLOGY	51,165	1,092	50,073			51,165
56	MEDICAL SUPPLIES CHARGED	479,620	13,047	466,573			479,620
59	DRUGS CHARGED TO PATIENTS	1,605,184	83,116	1,522,068			1,605,184
	OP PSYCH	803,364	12,836	790,528			803,364
61	OUTPAT SERVICE COST CNTRS						
62	EMERGENCY	1,629,875	57,493	1,572,382			1,629,875
	OBSERVATION BEDS (NON-DIS	258,770		258,770			258,770
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	298,392	9,573	288,819			298,392
101	SUBTOTAL	12,527,853	628,880	11,898,973			12,527,853
102	LESS OBSERVATION BEDS	258,770		258,770			258,770
103	TOTAL	12,269,083	628,880	11,640,203			12,269,083

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	1,027,142	1.286200	1.286200
40	ANESTHESIOLOGY	344,211	.160817	.160817
41	RADIOLOGY-DIAGNOSTIC	7,918,205	.244623	.244623
42	RADIOLOGY-THERAPEUTIC	1,144,001	.293933	.293933
44	LABORATORY	9,925,195	.187850	.187850
49	RESPIRATORY THERAPY	2,590,104	.377653	.377653
50	PHYSICAL THERAPY	1,310,689	.693660	.693660
52	SPEECH PATHOLOGY	89,539	.571427	.571427
55	MEDICAL SUPPLIES CHARGED	4,028,070	.119069	.119069
56	DRUGS CHARGED TO PATIENTS	8,195,753	.195856	.195856
59	OP PSYCH	1,540,591	.521465	.521465
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	3,916,136	.416195	.416195
62	OBSERVATION BEDS (NON-DIS	279,963	.924301	.924301
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,359,024	.219563	.219563
101	SUBTOTAL	43,668,623		
102	LESS OBSERVATION BEDS	279,963		
103	TOTAL	43,388,660		

Health Financial Systems	MCRIF32	FOR FAYETTE COUNTY HOSPITAL	**NOT A CMS WORKSHEET **	(09/2000)
CALCULATION OF OUTPATIENT SERVICE COST TO		I PROVIDER NO:	I PERIOD:	I PREPARED 5/27/2009
CHARGE RATIOS NET OF REDUCTIONS		I 14-1346	I FROM 1/ 1/2008	I WORKSHEET C
SPECIAL TITLE XIX WORKSHEET		I	I TO 12/31/2008	I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	1,321,110	105,009	1,216,101			1,321,110
	ANESTHESIOLOGY	55,355	1,341	54,014			55,355
41	RADIOLOGY-DIAGNOSTIC	1,936,978	178,092	1,758,886			1,936,978
42	RADIOLOGY-THERAPEUTIC	336,260	3,623	332,637			336,260
44	LABORATORY	1,864,446	89,525	1,774,921			1,864,446
49	RESPIRATORY THERAPY	978,161	41,426	936,735			978,161
50	PHYSICAL THERAPY	909,173	32,707	876,466			909,173
52	SPEECH PATHOLOGY	51,165	1,092	50,073			51,165
55	MEDICAL SUPPLIES CHARGED	479,620	13,047	466,573			479,620
56	DRUGS CHARGED TO PATIENTS	1,605,184	83,116	1,522,068			1,605,184
59	OP PSYCH	803,364	12,836	790,528			803,364
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,629,875	57,493	1,572,382			1,629,875
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	258,770		258,770			258,770
65	AMBULANCE SERVICES	298,392	9,573	288,819			298,392
101	SUBTOTAL	12,527,853	628,880	11,898,973			12,527,853
102	LESS OBSERVATION BEDS	258,770		258,770			258,770
103	TOTAL	12,269,083	628,880	11,640,203			12,269,083

#KST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
37	ANCILLARY SRVC COST CNTRS			
40	OPERATING ROOM	1,027,142	1.286200	1.286200
41	ANESTHESIOLOGY	344,211	.160817	.160817
42	RADIOLOGY-DIAGNOSTIC	7,918,205	.244623	.244623
44	RADIOLOGY-THERAPEUTIC	1,144,001	.293933	.293933
49	LABORATORY	9,925,195	.187850	.187850
50	RESPIRATORY THERAPY	2,590,104	.377653	.377653
52	PHYSICAL THERAPY	1,310,689	.693660	.693660
55	SPEECH PATHOLOGY	89,539	.571427	.571427
56	MEDICAL SUPPLIES CHARGED	4,028,070	.119069	.119069
59	DRUGS CHARGED TO PATIENTS	8,195,753	.195856	.195856
	OP PSYCH	1,540,591	.521465	.521465
61	OUTPUT SERVICE COST CNTRS			
62	EMERGENCY	3,916,136	.416195	.416195
	OBSERVATION BEDS (NON-DIS	279,963	.924301	.924301
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,359,024	.219563	.219563
101	SUBTOTAL	43,668,623		
102	LESS OBSERVATION BEDS	279,963		
103	TOTAL	43,388,660		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2009
I	14-1346	I	FROM 1/ 1/2008	I	WORKSHEET C
I		I	TO 12/31/2008	I	PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,278,542	1,027,142			
40	ANESTHESIOLOGY	54,351	377,448			
41	RADIOLOGY-DIAGNOSTIC	1,890,778	7,918,205			
42	RADIOLOGY-THERAPEUTIC	333,624	1,144,001			
44	LABORATORY	1,868,508	9,925,195			
49	RESPIRATORY THERAPY	974,442	2,701,358			
50	PHYSICAL THERAPY	905,250	1,310,689			
52	SPEECH PATHOLOGY	50,801	89,539			
55	MEDICAL SUPPLIES CHARGED	474,819	3,928,070			
56	DRUGS CHARGED TO PATIENTS	1,593,308	8,195,753			
59	OP PSYCH	793,096	1,540,591			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,799,002	3,916,136			
62	OBSERVATION BEDS (NON-DIS	260,143	279,963			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	316,626	1,359,024			
101	TOTAL	12,593,290	43,713,114			

#KST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS	1,278,542		1,278,542	1,027,142			
40	OPERATING ROOM	54,351		54,351	377,448			
41	ANESTHESIOLOGY	1,890,778		1,890,778	7,918,205			
42	RADIOLOGY-DIAGNOSTIC	333,624		333,624	1,144,001			
44	RADIOLOGY-THERAPEUTIC	1,868,508	27,083	1,895,591	9,925,195			
49	LABORATORY	974,442		974,442	2,701,358			
50	RESPIRATORY THERAPY	905,250		905,250	1,310,689			
52	PHYSICAL THERAPY	50,801		50,801	89,539			
55	SPEECH PATHOLOGY	474,819		474,819	3,928,070			
56	MEDICAL SUPPLIES CHARGED	1,593,308		1,593,308	8,195,753			
59	DRUGS CHARGED TO PATIENTS	793,096		793,096	1,540,591			
	OP PSYCH							
61	OUTPUT SERVICE COST CNTRS							
62	EMERGENCY	1,799,002	653,354	2,452,356	3,916,136			
	OBSERVATION BEDS (NON-DIS	260,143		260,143	279,963			
	OTHER REIMBURS COST CNTRS							
65	AMBULANCE SERVICES	316,626		316,626	1,359,024			
101	TOTAL	12,593,290	680,437	13,273,727	43,713,114			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1.286200		1.286200		
40	ANESTHESIOLOGY	.160817		.160817		
41	RADIOLOGY-DIAGNOSTIC	.244623		.244623		
42	RADIOLOGY-THERAPEUTIC	.293933		.293933		
44	LABORATORY	.187850		.187850		
49	RESPIRATORY THERAPY	.377653		.377653		
50	PHYSICAL THERAPY	.693660		.693660		
52	SPEECH PATHOLOGY	.571427		.571427		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.119069		.119069		
56	DRUGS CHARGED TO PATIENTS	.195856		.195856		
59	OP PSYCH	.521465		.521465		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.416195		.416195		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.924301		.924301		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.219563		.219563		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

		Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	Cost Center Description	4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		398,122			
40	ANESTHESIOLOGY		139,843			
41	RADIOLOGY-DIAGNOSTIC		2,493,163			
42	RADIOLOGY-THERAPEUTIC		515,473			
44	LABORATORY		3,548,346			
49	RESPIRATORY THERAPY		1,020,145			
50	PHYSICAL THERAPY		377,570			
52	SPEECH PATHOLOGY		5,590			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		986,439			
56	DRUGS CHARGED TO PATIENTS		926,374			
59	OP PSYCH		1,523,137			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		949,115			
62	OBSERVATION BEDS (NON-DISTINCT PART)		142,946			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		13,026,263			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		13,026,263			

TITLE XVIII, PART B

HOSPITAL

All Other

Hospital I/P
Part B Charges

Hospital I/P
Part B Costs

Cost Center Description

9

10

11

(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	512,065		
40	ANESTHESIOLOGY	22,489		
41	RADIOLOGY-DIAGNOSTIC	609,885		
42	RADIOLOGY-THERAPEUTIC	151,515		
44	LABORATORY	666,557		
49	RESPIRATORY THERAPY	385,261		
50	PHYSICAL THERAPY	261,905		
52	SPEECH PATHOLOGY	3,194		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,454		
56	DRUGS CHARGED TO PATIENTS	181,436		
59	OP PSYCH	794,263		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	395,017		
62	OBSERVATION BEDS (NON-DISTINCT PART)	132,125		
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	SUBTOTAL	4,233,166		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	4,233,166		

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1
2	PROGRAM VACCINE CHARGES	.195856
3	PROGRAM COSTS	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL	INPAT PROGRAM	OLD CAPITAL	
LINE NO.		RELATED COST	RELATED COST	CHARGES	CHARGES	CST/CHRG RATIO	COSTS
		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OP PSYCH						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

#KST A	COST CENTER DESCRIPTION	NEW CAPITAL
LINE NO.		CST/CHRG RATIO COSTS
		7 8
37	ANCILLARY SRVC COST CNTRS	
40	OPERATING ROOM	
41	ANESTHESIOLOGY	
42	RADIOLOGY-DIAGNOSTIC	
44	RADIOLOGY-THERAPEUTIC	
49	LABORATORY	
50	RESPIRATORY THERAPY	
52	PHYSICAL THERAPY	
55	SPEECH PATHOLOGY	
56	MEDICAL SUPPLIES CHARGED	
59	DRUGS CHARGED TO PATIENTS	
	OP PSYCH	
61	OUTPAT SERVICE COST CNTRS	
62	EMERGENCY	
	OBSERVATION BEDS (NON-DIS	
65	OTHER REIMBURS COST CNTRS	
101	AMBULANCE SERVICES	
	TOTAL	

TITLE XVIII, PART A		SKILLED NURSING FACILITY		PPS					
WKST A	COST CENTER DESCRIPTION	NONPHYSICIAN		MED ED NRS	MED ED ALLIED	MED ED ALL	BLOOD CLOT FOR		
LINE NO.		ANESTHETIST		SCHOOL COST	HEALTH COST	OTHER COSTS	HEMOPHILIACS		
		1	1.01	2	2.01	2.02	2.03		
	ANCILLARY SRVC COST CNTRS								
37	OPERATING ROOM								
40	ANESTHESIOLOGY								
41	RADIOLOGY-DIAGNOSTIC								
42	RADIOLOGY-THERAPEUTIC								
44	LABORATORY								
49	RESPIRATORY THERAPY								
50	PHYSICAL THERAPY								
52	SPEECH PATHOLOGY								
55	MEDICAL SUPPLIES CHARGED								
56	DRUGS CHARGED TO PATIENTS								
59	OP PSYCH								
	OUTPAT SERVICE COST CNTRS								
61	EMERGENCY								
62	OBSERVATION BEDS (NON-DIS								
	OTHER REIMBURS COST CNTRS								
65	AMBULANCE SERVICES								
101	TOTAL								

Health Financial Systems	MCRIF32	FOR FAYETTE COUNTY HOSPITAL	IN LIEU OF FORM CMS-2552-96(04/2005) CONTD		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE		I	PROVIDER NO:	I PERIOD:	I PREPARED 5/27/2009
OTHER PASS THROUGH COSTS		I	14-1346	I FROM 1/ 1/2008	I WORKSHEET D
		I	COMPONENT NO:	I TO 12/31/2008	I PART IV
		I	14-5499	I	I

TITLE XVIII, PART A	SKILLED NURSING FACILITY	PPS
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WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P CST 5.01	RATIO OF TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS								
37	OPERATING ROOM			1,027,142				6,832	
40	ANESTHESIOLOGY			344,211					
41	RADIOLOGY-DIAGNOSTIC			7,918,205				37,126	
42	RADIOLOGY-THERAPEUTIC			1,144,001				7,066	
44	LABORATORY			9,925,195				222,457	
49	RESPIRATORY THERAPY			2,590,104				210,798	
50	PHYSICAL THERAPY			1,310,689				152,398	
52	SPEECH PATHOLOGY			89,539				5,730	
55	MEDICAL SUPPLIES CHARGED			4,028,070				174,428	
56	DRUGS CHARGED TO PATIENTS			8,195,753				1,269,643	
59	OP PSYCH			1,540,591					
	OUTPAT SERVICE COST CNTRS								
61	EMERGENCY			3,916,136					
62	OBSERVATION BEDS (NON-DIS			279,963					
	OTHER REIMBURS COST CNTRS								
65	AMBULANCE SERVICES								
101	TOTAL			42,309,599				2,086,478	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	COL 8.01	COL 8.02
		CHARGES	D,V COL 5.03	D,V COL 5.04	PASS THRU COST	* COL 5	* COL 5
		8	8.01	8.02	9	9.01	9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
42	RADIOLOGY-THERAPEUTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	OP PSYCH						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES						
101	TOTAL						

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XIX - O/P

HOSPITAL

		PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
	Cost Center Description	5.01	5.02	5.03	6	7
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
42	RADIOLOGY-THERAPEUTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
52	SPEECH PATHOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	OP PSYCH					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

TITLE XIX - O/P

HOSPITAL

		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		338,142			
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC		417,387			
42	RADIOLOGY-THERAPEUTIC		30,919			
44	LABORATORY		247,288			
49	RESPIRATORY THERAPY		57,557			
50	PHYSICAL THERAPY		113,366			
52	SPEECH PATHOLOGY		2,553			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		38,712			
56	DRUGS CHARGED TO PATIENTS		67,111			
59	OP PSYCH					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		587,925			
62	OBSERVATION BEDS (NON-DISTINCT PART)		34,114			
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES		60,687			
101	SUBTOTAL		1,995,761			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		1,995,761			

(A) WORKSHEET A LINE NUMBERS

(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII PART A	HOSPITAL	OTHER
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,166
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,770
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,770
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,383
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,446
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,383
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	90.92
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	90.92
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,906,298
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,182
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	780,876
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,125,422

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,551
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,551
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.828770
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	680.25
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,125,422

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	563.77
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,378,981
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,378,981

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	563,654	331	1,702.88	234	398,474
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

1

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	779,694
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	779,694
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A	HOSPITAL	OTHER
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PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	459
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	563.77
85	OBSERVATION BED COST	258,770

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII PART A	SNF	PPS
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,172
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,172
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,172
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,800
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	937,572
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	937,572

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	305,181
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	305,181
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	3.072183
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	140.51
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	937,572

TITLE XVIII PART A	SNF	PPS
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PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1 937,572
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	431.66
68	PROGRAM ROUTINE SERVICE COST	776,988
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	776,988
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	19,617
72	PER DIEM CAPITAL-RELATED COSTS	9.03
73	PROGRAM CAPITAL-RELATED COSTS	16,254
74	INPATIENT ROUTINE SERVICE COST	760,734
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	760,734
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	776,988
80	PROGRAM INPATIENT ANCILLARY SERVICES	519,765
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	1,296,753

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
85	OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XIX - I/P	HOSPITAL	OTHER
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,166
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,770
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,770
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,383
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	378
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,906,298
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	780,012
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,126,286

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,551
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,551
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.829107
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	680.25
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,126,286

TITLE XIX - I/P	HOSPITAL	OTHER
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PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	564.00
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	213,192
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	213,192

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	563,654	331	1,702.88		
44	INTENSIVE CARE UNIT				
45	CORONARY CARE UNIT				
46	BURN INTENSIVE CARE UNIT				
47	SURGICAL INTENSIVE CARE UNIT				
	OTHER SPECIAL CARE				
48					1
	PROGRAM INPATIENT ANCILLARY SERVICE COST				381,117
49	TOTAL PROGRAM INPATIENT COSTS				594,309

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XIX - I/P	HOSPITAL	OTHER
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PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	459
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	564.00
85	OBSERVATION BED COST	258,876

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XIX - I/P	SNF	OTHER
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,172
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,172
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,172
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	305,181
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	305,181
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	140.51
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

TITLE XIX - I/P	SNF	OTHER
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PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	19,617
72	PER DIEM CAPITAL-RELATED COSTS	9.03
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
85	OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XIX - I/P	NF	OTHER
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PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	22,855
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	22,855
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	22,855
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,169,388
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,169,388
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	138.67
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

TITLE XIX - I/P	NF	OTHER
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PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	102,484
72	PER DIEM CAPITAL-RELATED COSTS	4.48
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
85	OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII, PART A		HOSPITAL	OTHER		
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
	INPAT ROUTINE SRVC CNTRS				
25	ADULTS & PEDIATRICS		1,321,852		
26	INTENSIVE CARE UNIT		196,456		
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	1.286200	71,132	91,490	
40	ANESTHESIOLOGY	.160817	15,674	2,521	
41	RADIOLOGY-DIAGNOSTIC	.244623	474,425	116,055	
42	RADIOLOGY-THERAPEUTIC	.293933	58,279	17,130	
44	LABORATORY	.187850	1,379,894	259,213	
49	RESPIRATORY THERAPY	.377653	927,643	350,327	
50	PHYSICAL THERAPY	.693660	53,234	36,926	
52	SPEECH PATHOLOGY	.571427	3,895	2,226	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.119069	1,131,089	134,678	
56	DRUGS CHARGED TO PATIENTS	.195856	2,519,794	493,517	
59	OP PSYCH	.521465			
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.416195	3,063	1,275	
62	OBSERVATION BEDS (NON-DISTINCT PART)	.924301			
	OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL		6,638,122	1,505,358	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		6,638,122		

TITLE XVIII, PART A		SWING BED SNF		OTHER	
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
25	INPAT ROUTINE SRVC CNTRS				
26	ADULTS & PEDIATRICS				
	INTENSIVE CARE UNIT				
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	1.286200	2,457	3,160	
40	ANESTHESIOLOGY	.160817			
41	RADIOLOGY-DIAGNOSTIC	.244623	65,827	16,103	
42	RADIOLOGY-THERAPEUTIC	.293933			
44	LABORATORY	.187850	263,049	49,414	
49	RESPIRATORY THERAPY	.377653	229,128	86,531	
50	PHYSICAL THERAPY	.693660	85,067	59,008	
52	SPEECH PATHOLOGY	.571427	3,391	1,938	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.119069	160,041	19,056	
56	DRUGS CHARGED TO PATIENTS	.195856	944,594	185,004	
59	OP PSYCH	.521465			
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.416195			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.924301			
	OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL		1,753,554	420,214	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		1,753,554		

TITLE XVIII, PART A		SKILLED NURSING FACILITY		PPS	
#KST A	CDST CENTER DESCRIPTION	RATID COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
25	INPAT ROUTINE SRVC CNTRS				
26	ADULTS & PEDIATRICS				
	INTENSIVE CARE UNIT				
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	1.286200	6,832	8,787	
40	ANESTHESIOLOGY	.160817			
41	RADIOLOGY-DIAGNOSTIC	.244623	37,126	9,082	
42	RADIOLOGY-THERAPEUTIC	.293933	7,066	2,077	
44	LABORATORY	.187850	222,457	41,789	
49	RESPIRATORY THERAPY	.377653	210,798	79,608	
50	PHYSICAL THERAPY	.693660	152,398	105,712	
52	SPEECH PATHOLOGY	.571427	5,730	3,274	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.119069	174,428	20,769	
56	DRUGS CHARGED TO PATIENTS	.195856	1,269,643	248,667	
59	OP PSYCH	.521465			
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.416195			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.924301			
	OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL		2,086,478	519,765	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		2,086,478		

TITLE XIX		HOSPITAL	OTHER		
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
25	INPAT ROUTINE SRVC CNTRS				
26	ADULTS & PEDIATRICS		215,860		
	INTENSIVE CARE UNIT		26,864		
	ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM	1.286200	86,924	111,802	
40	ANESTHESIOLOGY	.160817			
41	RADIOLOGY-DIAGNOSTIC	.244623	293,683	71,842	
42	RADIOLOGY-THERAPEUTIC	.293933	5,397	1,586	
44	LABORATORY	.187850	237,416	44,599	
49	RESPIRATORY THERAPY	.377653	17,678	6,676	
50	PHYSICAL THERAPY	.693660	2,489	1,727	
52	SPEECH PATHOLOGY	.571427	282	161	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.119069	166,562	19,832	
56	DRUGS CHARGED TO PATIENTS	.195856	422,161	82,683	
59	OP PSYCH	.521465			
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.416195	73,686	30,668	
62	OBSERVATION BEDS (NON-DISTINCT PART)	.924301	10,322	9,541	
	OTHER REIMBURS COST CNTRS				
65	AMBULANCE SERVICES				
101	TOTAL		1,316,600	381,117	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		1,316,600		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/27/2009
I	14-1346	I	FROM 1/ 1/2008	I	WORKSHEET E
I	COMPONENT NO:	I	TO 12/31/2008	I	PART B
I	14-1346	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,233,166
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,233,166
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,275,498
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	42,381
18.01	CAH ACTUAL BILLED COINSURANCE	1,893,986
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,339,131
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,339,131
24	PRIMARY PAYER PAYMENTS	437
25	SUBTOTAL	2,338,694
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	459,313
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	459,313
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	2,798,007
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,798,007
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,610,134
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	187,873
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	
	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TITLE XVIII		HOSPITAL			
DESCRIPTION		INPATIENT-PART A		P A R T B	
		MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
		1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,978,190		2,374,134
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER .01	3/26/2009	89,700	12/31/2008	236,000
	ADJUSTMENTS TO PROVIDER .02				
	ADJUSTMENTS TO PROVIDER .03				
	ADJUSTMENTS TO PROVIDER .04				
	ADJUSTMENTS TO PROVIDER .05				
	ADJUSTMENTS TO PROGRAM .50				
	ADJUSTMENTS TO PROGRAM .51				
	ADJUSTMENTS TO PROGRAM .52				
	ADJUSTMENTS TO PROGRAM .53				
	ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99			89,700		236,000
4 TOTAL INTERIM PAYMENTS			3,067,890		2,610,134
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER .01				
	TENTATIVE TO PROVIDER .02				
	TENTATIVE TO PROVIDER .03				
	TENTATIVE TO PROGRAM .50				
	TENTATIVE TO PROGRAM .51				
	TENTATIVE TO PROGRAM .52				
SUBTOTAL .99			NONE		NONE
6 DETERMINED NET SETTLEMENT					
	AMOUNT (BALANCE DUE) .01				187,873
	BASED ON COST REPORT (1) .02		174,599		
7 TOTAL MEDICARE PROGRAM LIABILITY			2,893,291		2,798,007
NAME OF INTERMEDIARY:					
INTERMEDIARY NO:					
SIGNATURE OF AUTHORIZED PERSON: _____					
DATE: ____/____/____					

1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII		SNF				
DESCRIPTION		INPATIENT-PART A	P A R T		B	
		MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		514,026			
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER		.01			
	ADJUSTMENTS TO PROVIDER		.02			
	ADJUSTMENTS TO PROVIDER		.03			
	ADJUSTMENTS TO PROVIDER		.04			
	ADJUSTMENTS TO PROVIDER		.05			
	ADJUSTMENTS TO PROGRAM		.50			
	ADJUSTMENTS TO PROGRAM		.51			
	ADJUSTMENTS TO PROGRAM		.52			
	ADJUSTMENTS TO PROGRAM		.53			
	ADJUSTMENTS TO PROGRAM		.54			
	SUBTOTAL		.99			
4	TOTAL INTERIM PAYMENTS		NONE		NONE	
			514,026			
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER		.01			
	TENTATIVE TO PROVIDER		.02			
	TENTATIVE TO PROVIDER		.03			
	TENTATIVE TO PROGRAM		.50			
	TENTATIVE TO PROGRAM		.51			
	TENTATIVE TO PROGRAM		.52			
	TENTATIVE TO PROGRAM		.99			
	SUBTOTAL		.99			
6	DETERMINED NET SETTLEMENT		NONE		NONE	
	AMOUNT (BALANCE DUE)					
	BASED ON COST REPORT (1)					
7	TOTAL MEDICARE PROGRAM LIABILITY		514,026			
NAME OF INTERMEDIARY:						
INTERMEDIARY NO:						
SIGNATURE OF AUTHORIZED PERSON: _____						
DATE: ____/____/____						

1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII		SWING BED SNF					
DESCRIPTION		INPATIENT-PART A		P A R T B			
		MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT		
		1	2	3	4		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,082,190				
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE		
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)							
	ADJUSTMENTS TO PROVIDER	.01	12/31/2008		82,900		
	ADJUSTMENTS TO PROVIDER	.02					
	ADJUSTMENTS TO PROVIDER	.03					
	ADJUSTMENTS TO PROVIDER	.04					
	ADJUSTMENTS TO PROVIDER	.05					
	ADJUSTMENTS TO PROGRAM	.50					
	ADJUSTMENTS TO PROGRAM	.51					
	ADJUSTMENTS TO PROGRAM	.52					
	ADJUSTMENTS TO PROGRAM	.53					
	ADJUSTMENTS TO PROGRAM	.54					
SUBTOTAL		.99			82,900	NONE	
4 TOTAL INTERIM PAYMENTS					1,165,090		
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)							
	TENTATIVE TO PROVIDER	.01					
	TENTATIVE TO PROVIDER	.02					
	TENTATIVE TO PROVIDER	.03					
	TENTATIVE TO PROGRAM	.50					
	TENTATIVE TO PROGRAM	.51					
	TENTATIVE TO PROGRAM	.52					
SUBTOTAL		.99			NONE	NONE	
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)					21,345		
	SETTLEMENT TO PROVIDER	.01					
	SETTLEMENT TO PROGRAM	.02					
7 TOTAL MEDICARE PROGRAM LIABILITY					1,186,435		
NAME OF INTERMEDIARY:							
INTERMEDIARY NO:							
SIGNATURE OF AUTHORIZED PERSON:							
DATE: ____/____/____							

1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII

SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	787,491	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	424,416	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,383	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,211,907	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,211,907	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,211,907	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	25,472	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,186,435	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,186,435	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,165,090	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	21,345	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT
HOSPITAL

1	INPATIENT SERVICES	3,282,813
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,282,813
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,315,641
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	3,315,641
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	546,495
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,769,146
23	COINSURANCE	3,584
24	SUBTOTAL	2,765,562
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	127,729
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	127,729
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,893,291
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FRDM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	2,893,291
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,067,890
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-174,599
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XVIII	SNF	PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE			
1	INPATIENT HOSPITAL/SNF/NF SERVICES			
2	MEDICAL AND OTHER SERVICES			
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
6	SUBTOTAL			
7	INPATIENT PRIMARY PAYER PAYMENTS			
8	OUTPATIENT PRIMARY PAYER PAYMENTS			
9	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
	PAYMENT FOR SERVICES ON A CHARGE BASIS			
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
19	RATIO OF LINE 17 TO LINE 18			
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
23	COST OF COVERED SERVICES			
	PROSPECTIVE PAYMENT AMOUNT			
24	OTHER THAN OUTLIER PAYMENTS			592,874
25	OUTLIER PAYMENTS			
26	PROGRAM CAPITAL PAYMENTS			
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
30	SUBTOTAL			592,874
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE			592,874
	XVIII ENTER AMOUNT FROM LINE 30			
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
34	EXCESS OF REASONABLE COST			
35	SUBTOTAL			592,874
36	COINSURANCE			78,848
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)			514,026
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
	PAYMENT FOR SERVICES ON A CHARGE BASIS			
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
	FOR PAYMENT OF PART A SERVICES			
45	RATIO OF LINE 43 TO 44			
46	TOTAL CUSTOMARY CHARGES			
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
50	OTHER ADJUSTMENTS (SPECIFY)			
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
52	SUBTOTAL			514,026
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER			514,026
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
57	INTERIM PAYMENTS			514,026
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)
I PROVIDER NO: I PERIOD: I PREPARED 5/27/2009
I 14-1346 I FROM 1/ 1/2008 I WORKSHEET E-3
I COMPONENT NO: I TO 12/31/2008 I PART III
I 14-5499 I I

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII	SNF	PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
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58 BALANCE DUE PROVIDER/PROGRAM
59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-689,688			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	8,583,901			
5	OTHER RECEIVABLES	407,464			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,202,160			
7	INVENTORY	164,501			
8	PREPAID EXPENSES	88,544			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	16,666			
11	TOTAL CURRENT ASSETS	4,369,228			
FIXED ASSETS					
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS				
14.01	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	3,525,032			
16.01	LESS ACCUMULATED DEPRECIATION	-1,776,052			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	1,748,980			
OTHER ASSETS					
22	INVESTMENTS	5,978			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	15,481			
26	TOTAL OTHER ASSETS	21,459			
27	TOTAL ASSETS	6,139,667			

		GENERAL	SPECIFIC	ENDOWMENT	PLANT
		FUND	PURPOSE	FUND	FUND
LIABILITIES AND FUND BALANCE			FUND		
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	768,420			
29	SALARIES, WAGES & FEES PAYABLE	718,210			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	1,690,100			
32	DEFERRED INCOME	391,762			
33	ACCELERATED PAYMENTS	464,034			
34	DUE TO OTHER FUNDS	366,872			
35	OTHER CURRENT LIABILITIES	17,458			
36	TOTAL CURRENT LIABILITIES	4,416,856			
LONG TERM LIABILITIES					
37	MORTGAGE PAYABLE	739,701			
38	NOTES PAYABLE				
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	739,701			
43	TOTAL LIABILITIES	5,156,557			
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	983,110			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	983,110			
52	TOTAL LIABILITIES AND FUND BALANCES	6,139,667			

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		1,971,423		
2	NET INCOME (LOSS)		-17,155		
3	TOTAL		1,954,268		
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	0				
6	0				
7	0				
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		1,954,268		
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	0		971,158		
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		971,158		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		983,110		

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5	0				
6	0				
7	0				
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13	0				
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,564,551		2,564,551
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	305,181		305,181
7 00 NURSING FACILITY	3,169,388		3,169,388
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	6,039,120		6,039,120
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	275,376		275,376
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	275,376		275,376
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	6,314,496		6,314,496
17 00 ANCILLARY SERVICES	14,347,212	28,731,279	43,078,491
18 00 OUTPATIENT SERVICES			
20 00 AMBULANCE SERVICES		1,359,024	1,359,024
24 00 PHYSICIAN CHARGES	335,471	1,873,193	2,208,664
25 00 TOTAL PATIENT REVENUES	20,997,179	31,963,496	52,960,675

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		23,266,155	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)	52,255		
35 00	985,876		
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		1,038,131	
40 00 TOTAL OPERATING EXPENSES		22,228,024	

DESCRIPTION		
1	TOTAL PATIENT REVENUES	52,960,675
2	LESS: ALLOWANCES AND DISCOUNTS ON	31,064,928
3	NET PATIENT REVENUES	21,895,747
4	LESS: TOTAL OPERATING EXPENSES	22,228,024
5	NET INCOME FROM SERVICE TO PATIENT	-332,277
OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	
24.05		702,650
24.10		
25	TOTAL OTHER INCOME	702,650
26	TOTAL	370,373
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	387,528
28		
29		
30	TOTAL OTHER EXPENSES	387,528
31	NET INCOME (OR LOSS) FOR THE PERIO	-17,155